ANNALS OF THE NEW YORK ACADEMY OF SCIENCES

VOLUME 63, ART. 3, PAGES 319–432

Editor

ROY WALDO MINER

PSYCHOTHERAPY AND COUNSELING

BY

LAWRENCE K. FRANK AND ROLLO MAY (*Conference Co-Chairmen*), F. H. ALLEN, L. N. AUSTIN, P. DAVID, P. E. JOHNSON, G. A. KELLY, E. LINDEMANN, N. MAILLOUX, T. F. MCNAIR SCOTT, W. E. OATES, H. H. PERLMAN, W. G. PERRY, JR., N. SANFORD, R. W. WHITE, L. E. WOODWARD, AND P. ZLATCHIN

Consulting Editor

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NEW YORK

PUBLISHED BY THE ACADEMY

November 7, 1955

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PSYCHOTHERAPY AND COUNSELING*

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* This series of papers is the result of a conference on *Psychotherapy and Counseling* held by the Section of Psychology of The New York Academy of Sciences, December 3 and 4, 1954. The conference and the resulting monograph were made possible by a grant from CIBA Pharmaceutical Products, Summit, N. J.

FOREWORD

By Rollo May
New York, N. Y.

A brief resumé of the history and the special features of the conference on which this monograph is based may prove useful. The idea arose originally in a discussion between Florence Powdermaker and Rollo May on the urgent need for clarification of the fields of counseling and psychotherapy. Lawrence Frank then became chairman of the organizing committee, which consisted of the above three persons and Harry Bone, Nevitt Sanford, Exie Welsch, Frances M. Wilson, and Luther E. Woodward.

The committee, after discussion, came to the conclusion that the most fruitful way to approach these topics would be to have commissions from the various disciplines engaged in different kinds of psychotherapy and counseling study the work of their professions and present considered statements on the topics outlined below. Participants in the conference were members from the five following professions: medicine; psychology; social work; the ministry; and counseling and guidance.

The purpose was to describe the current common and accepted practice by which each of these professions seeks to meet those human needs that can be helped by psychotherapy and counseling, however designated, and to describe also the particular training now being provided. The conference was the first step toward what may become a series of explorations and interprofessional discussions in which the issues involved in the training and practice of psychotherapy and counseling will be progressively clarified, with a view to the improvement both of the professional services in each profession and the interrelations among these professions.

Preparatory commissions, made up of five to eight members of each of the above professions, met over the eight months preceding the conference to review their experience and formulate their views on the following topics. What kinds of persons with what kinds of problems does their profession seek to help by means of psychotherapy or counseling, in individual and group therapy? What methods and practices does their profession use in seeking to help these persons? What kind of training—preprofessional, professional, and supervised experience—is now being provided to prepare practitioners for giving such services? Under what circumstances does the profession collaborate with one or another of these professions, and what is the part of each in this collaboration? How are the persons to be trained selected? What are the social expectations and sanctions inherent in the situation in which each profession functions, and how do these influence the practice of the profession? By what methods and techniques does each profession critically examine its own work and seek to advance its professional competence?

At the conference, each of the five commissions presented the consensus and differing views of their members before an invited group, which then participated in discussions of the findings. The presentations follow.

PERSONNEL OF THE COMMISSIONS FOR THE CONFERENCE ON PSYCHOTHERAPY AND COUNSELING

The Commission in Medicine

Frederick Allen, M.D., Chairman, Clinical Professor of Psychiatry, University of Pennsylvania Medical School, Philadelphia, Pa.

William Cooper, M.D., Attending Orthopedic Surgeon, Hospital for Special Surgery, New York, N. Y.

Louis Martin Fraad, M.D., Assistant Clinical Professor of Pediatrics, Cornell University Medical College, New York, N. Y.

Florence Powdermaker, M.D., Associate, William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, New York, N. Y.

Robert F. Sooley, M.D., Attending Physician, St. Luke's Hospital, New York, N. Y.

Exie Welsch, M.D., Instructor, Department of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, N. Y.

The Commission in Psychology

Nevitt Sanford, Ph.D., Chairman, Mary Conover Mellon Foundation, Vassar College, Poughkeepsie, N. Y.

Peter Blos, Ph.D., Child Psychoanalyst, New York, N. Y.

Harry Bone, Ph.D., Fellow, William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, New York, N. Y.

Arthur Combs, Ph.D., Professor of Clinical Psychology, University of Florida, Gainesville, Fla.

George Klein, Ph.D., Associate Professor, Graduate Department of Psychology, New York University, N. Y.

Rollo May, Ph.D., Fellow, William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, New York, N. Y.

The Commission in Social Work

Luther E. Woodward, Ph.D., Chairman, Coordinator, Community Health Services, New York State Mental Health Commission, New York, N. Y.

Margaret Blenkner, M.S., Assistant Director, Institute of Welfare Research, Community Service Society, New York, N. Y.

Robert Gomberg, Ph.D., Executive Director, Jewish Family Service, New York, N. Y.

Alice McCabe, M.S., Director, East River District Office, Community Service Society, New York, N. Y.

Sonia Penn, M.S., Private Practice, Counseling, New York, N. Y.

Clara Rabinowitz, M.S., Northside Center for Child Development, New York, N. Y.

Mira Talbot, Ph.D., Acting Borough Supervisor of Social Workers, Queens Center, Bureau of Child Guidance, New York City Board of Education, New York, N. Y.

The Commission in Counseling and Guidance

Frances M. Wilson, Ph.D., Chairman, Director of Guidance, New York City Board of Education, New York, N. Y.

Ruth Andrus, Ph.D., Director, Cold Spring Institute of the Walt Foundation, Inc., Cold Spring-on-Hudson, New York.

Morris Krugman, Ph.D., Assistant Superintendent, New York City Board of Education, New York, N. Y.

Isabel Mason, Teacher, William Cullen Bryant High School, Long Island City, N. Y.

Janet Fowler Nelson, Ph.D., American Association of Marriage Counselors, New York, N. Y.

William G. Perry, Jr., A.M., Director Bureau of Student Counseling, Harvard University, Cambridge, Mass.

Leonard W. Rockower, Supervisor, Psychiatric Service, University of the State of New York, Brooklyn, N. Y.

The Commission in the Ministry

The Rev. Wayne E. Oates, Th.D., Chairman, Professor, Southern Baptist Theological Seminary, Louisville, Ky.

Father William C. Bier, S.J., Ph.D., Assistant Professor of Psychology, Fordham University, New York, N. Y.

Father Charles A. Curran, Ph.D., Chaplain, St. Charles College-Seminary, Columbus, Ohio.

The Rev. Rollin Fairbanks, Ph.D., Professor, Episcopal School of Theology, Cambridge, Mass.

The Rev. Joseph Fletcher, Ph.D., Professor, Episcopal School of Theology, Cambridge, Mass.

The Rev. Seward Hiltner, Ph.D., Acting Dean, Federated Theological Faculty, University of Chicago, Chicago, Ill.

Rabbi Fred Hollander, B.S., Director, Institute for Pastoral Psychiatry of the New York Board of Rabbis, New York, N. Y.

The Rev. Reuel Howe, Ph.D., Professor of Pastoral Psychology, Virginia Theological Seminary, Richmond, Va.

The Rev. Frederick Kuether, B.D., Director, Council for Clinical Training, New York, N. Y.

The Rev. Robert Leslie, Ph.D., Professor of Pastoral Psychology, School of Theology, Boston University, Boston, Mass.

THE FINDINGS OF THE COMMISSION IN MEDICINE

Presented by Frederick H. Allen*
University of Pennsylvania Medical School, Philadelphia, Pa.

The Medical Commission participating in the work described in this monograph included psychiatrists, an internist, an orthopedist, and a pediatrician. In the several meetings held by this group, the important question posed by the outline for the conference on which this monograph is based concerned opportunities in the various frames of medical practice to apply sound psychological principles in the process of treating patients. The major question is whether the physician functioning within the opportunities created when a patient seeks and needs his special skill can apply sound psychological principles relevant to the situation as he diagnoses the illness and carries out the treatment. Can he, in the framework of his own competence and professional opportunity, provide a psychologically therapeutic atmosphere without the primary intent of becoming a psychotherapist, which is the major function of the psychiatrist?

The rapid advances of our knowledge of medical conditions have placed more effective tools in the hands of physicians. At the same time, this trend has increased the need for specialization in medical practice since it has become increasingly difficult for a physician to keep abreast of the times in both knowledge and skill. Specialization can lead to such fragmentation of concern that attention may be limited to the condition needing specialized skill and away from the common denominator in all practice—the living, feeling human being in whom the condition exists. Pediatricians, surgeons, internists, orthopedists, dermatologists, obstetricians, and on through the lists of specialists of modern medicine have, as their common concern, not just the condition but the human being who, in varying degrees, is anxious about himself, not just the symptom. The conditions of illness present the individual and the family with minor or major crises, and arouse emotions which not only influence the course of treatment but, many times, are important etiological factors in the illness.

Psychiatry, as one of the newer specialties in medical practice, has and is having a reintegrating influence. The primary concern of the psychiatrist is the adequacy of the functioning of the human being as he attempts to adapt to the biological and social forces which make up the day-to-day realities of his living. Psychiatry has contributed to the physician a deeper understanding of the emotional life of the patient and also has sharpened his sensitivity to the emotional components of illness. The commission considered the application of this knowledge by the specialist and general practitioner and the opportunities to apply sound psychological principles in the course of treatment, even though the physician has been selected by the patient because of his particular skill to treat the physical condition for which help is being sought.

The term "psychosomatic" has gained wide usage in the modern medical scene, and this fact indicates the degree of acceptance of the significance of

* This paper, presented by Doctor Allen at the conference on which this monograph is based, was written by him in collaboration with the other members of the Commission in Medicine.

emotional disturbances in physical illness. The term can be misleading if it delineates a particular type of medical practice. But as the concepts which the term represents become an integral part of all medical practice, the term itself may well disappear. The practice of medicine will become more comprehensive as each physician within the framework of his own competence and professional opportunity is able to understand and deal with the emotional life of his patient as it is relevant to his relation to the patient and the necessary treatment.

It is this last point that is the keystone of the commission's deliberations. Although functioning within the limits of his specialty, the surgeon, orthopedist, pediatrician, *etc.*, who is sensitive to the emotional needs of his patient, is able to exert a profound therapeutic influence not only on the condition being treated, but on the patient as a person and as an active participant in becoming well.

Being ill in itself causes the patient and his family to be anxious. At times, this anxiety may be so exaggerated as to lead to distortions of the symptoms. The physician, by his sensitivity to the attitudes of the patient and his family, becomes a potent influence in strengthening the patient's capacity to face his illness more realistically, and in diminishing possible residuals. The respect the physician has for his own skill in the areas of his competence, together with the respect he has for the patient and his family to deal with illness, creates an emotional atmosphere that is profoundly therapeutic.

There are many examples. I am sure that every physician who is sensitive to the emotional needs of his patient and to the kind of deep respect that he can arouse helps that patient to live with what are sometimes very crippling and sometimes very dangerous illness situations. In such circumstances, the physician is related not only to the death potential or to the crippling potential contained in the illness, but also to the quality in the patient that enables him to be more related to the life processes than to the danger aspect of the illness condition.

Anxiety is highly infectious. Frequently the physician, on entering a highly charged atmosphere, has the opportunity of introducing into it a particular professional quality that transmits to the family and patient a feeling that here is a person upon whom they can rely, although their reactions may be doubt and fear. In helping the patient live through these reactions, the physician has a most helpful psychotherapeutic influence. A good example of such therapeutic influence is provided by a profession not represented in this commission. Fear of dental experience is particularly common in children. The skillful practitioner, sensing the fear, proceeds slowly but confidently with what needs to be done. Rather than give the child false assurances, he lets the child know that the ensuing procedure may hurt him. He communicates his belief that the child can endure the pain, and proceeds with what he has to do with sureness and obvious care and sensitivity. In so doing, he is being psychotherapeutic within the framework of his professional skill and opportunity.

Illness or physical disability re-establishes or accentuates a state of dependency. This arouses certain emotional reactions from both the patient and the family that need to be taken into consideration by the physician. Two ex-

tremes frequently may be encountered: the patient may slump into a state of helplessness and let anyone carry the responsibility who will, or he may make a determined struggle against dependency with attempts to deny or minimize the illness. Doctor Cooper of this commission, in his work with physically handicapped children, brought out very clearly the debilitating effects of dependency encouraged by overanxious parents who have no expectation that the child can do anything on his own. The paralyzing effects of such a milieu are obvious and can defeat all efforts to rehabilitate the child, no matter how much massage, exercise, *etc.* are given.

With Doctor Cooper's permission, we include in this statement the introduction to his article "The Problem of Social and Emotional Adjustment in Cerebral Palsy":

"Extensive clinical observation in cerebral palsy suggests a need for re-evaluation of the problem with emphasis on aspects other than medical. For years the weight of concern has been with the obvious physical restrictions and the evolution of specific methods for treating them. Such treatment has usually been limited to physical therapy, braces and surgery. The existence of social, emotional and other needs has been vaguely recognized by the orthopedic surgeon but has either been ignored by him or consigned to specialists unfamiliar with the physical problem. Rarely has the fact been considered that other factors may often overshadow the orthopedic needs in importance. As orthopedic surgeons we have been too much concerned with what we actually see in our patients. We have dedicated ourselves to the correction of visible deformity, and in so doing have often neglected the person we were treating. This is particularly true in cerebral palsy. To be sure, the orthopedic aspects are important, but it is really other considerations which impose on the patient with cerebral palsy the dreadful degree of social isolation which is known in no other common medical condition."

The physician dealing with a physical condition is in a strategic position to help both patient and family to a new and constructive attitude. This principle of realistic expectation helps the patient to take a real part in his cure, and it applies in all illness.

The principle of staying with the patient's complaints long enough to understand their various meanings was emphasized over and over in the commission's deliberations, and it is a principle of primary importance in medical practice that includes the psychological aspects of the difficulties. Overimbued with the desire to apply psychotherapy, the physician, in his efforts to uncover emotional difficulties, all too often does not focus on the complaint. It was clear to the commission that physicians staying with the presenting reasons for seeking help create an atmosphere of trust in the interest of the doctor that later allows for deeper understanding of the emotional patterns that may turn out to be of primary importance. The patient feels the doctor's respect for what is being presented and the doctor takes his clues for further studies both from his examinations and from what the patient reveals to him as he goes along. A headache may turn out to be evidence of an acute anxiety or it may be a symptom of a serious physical condition. The physician who can be a sensitive and discriminating listener can gain an understanding of what the

patient is feeling. The bond of mutual respect that is started can lead to a partnership between patient and doctor in the process of getting well.

Training of the Physician

In recent years significant studies have been made in undergraduate medical education on the problem of orienting the student to human beings as feeling organisms, not as mere anatomical and physiological specimens. Courses in psychiatry, while still teaching more formal aspects, tend more and more to view the mental patient as a disturbed person attempting to adapt to the stresses and strains of everyday life rather than as an oddity presenting bizarre and foreign symptoms. Equally important is the desire to incorporate into clinical teaching better understanding of emotional difficulties as seen in the surgical ward, the gastrointestinal clinic, the pediatric ward, *etc.* The student learns some of the fundamentals of a more comprehensive understanding of illness and of the close relation of feelings and attitudes to physical conditions.

The commission stressed development of psychological insights appropriate to medical practice in various frames of reference, as well as greater opportunities for the deeper understanding of psychological principles as applied on the pediatric wards, the surgery, *etc.* In these wards, the student gains his first experience in being a doctor to a patient and not just to a condition. In taking a history, the student gains his first experience in relation to a person who is presenting both facts and feelings, recognizes the main concerns of the patient, and uses them as his focus of attention. The opportunities here are rich for understanding and dealing with emotional complexities without having to regard the patient as a psychiatric problem; for example, the frightened child in a pediatric ward who is afraid to leave an anxious mother, or the emotional stresses and strains of a patient with complaints suggestive of cardiac disorder, malignancy, *etc.*, who fears the worst as he presents himself for a medical examination. Some of the fears associated with illness are most realistic. Others reveal patterns of emotional response indicative of varying degrees of immaturity or the guilty feelings of a parent of a physically handicapped child. These few examples, which could be multiplied manyfold, indicate the types of emotional response with which the physician has to deal while staying with the condition for which physical help is needed. The physician does need to get training in a psychiatric ward or clinic to understand how he can help a patient with such reactions. He can acquire that skill within his own frame of reference as he learns to practice medicine in a more comprehensive way.

When a patient presents himself to a psychiatrist by his own choice or is referred by a physician who feels that the patient needs a skill different than his own, the psychiatric condition is the focus. When sensitively carried through, the referral itself may have important therapeutic value. The patient has been helped to sort out from his original complaint the emotional problems involved in his illness and, in accepting the value of the referral, he has taken a significant step toward doing something about these problems in the appropriate psychotherapeutic setting.

Psychiatry, as a specialty of medicine, has the same primary functions as other medical specialties, namely diagnosis and treatment. It differs from

other medical specialties in that the relationship to the doctor is more direct and personal and is a means of therapy. Psychiatry pursues the usual medical method of exploring the nature of the presenting symptoms from the standpoint of the patient's functioning as a human organism in its physical, emotional, intellectual, and environmental aspects. Actually, practice varies. The amount and nature of data from sources other than the psychiatrist's own observations is determined by the need for special or detailed knowledge supplied either by the referring doctor or other medical specialists and, at times, by psychological tests and data obtained by a social worker. Where physical illness is present, the psychiatrist aims to have a cooperative arrangement with the internist or other doctor on the case so that they may make a joint evaluation of the somatic and psychological aspects of the patient's difficulties and together evolve a plan for treatment, sometimes also calling on the psychologist, the social worker, vocational guidance worker, or minister for help in their spheres.

In the diagnostic process, it is the function of the psychiatrist to appraise the patient's capacity for objective reality and the subjective realities of the patient's inner world, and to evaluate the areas of distortion, confusion, and excessive or inappropriate reactions. Of first consideration is the patient's immediate anxiety, his wish for help, his fear of it and, sometimes, his insistence on organic causality. As in other medical procedures, the plan of therapy is based on the psychiatrist's estimation of the causal factors in the patient's symptomatology, his strengths and his weaknesses, his resources, and those of his environment relevant to his difficulties. Thus therapy may take many forms and even change its emphasis. Psychotherapy may be the sole approach or it may be combined with chemical and physiological procedures. These may be coordinated with supportive medication or treatment carried out by other physicians.

It is the nature and scope of medical responsibility during diagnostic and therapeutic processes to differentiate the work of the psychiatrist from that of his nonmedical confreres. The psychiatrist's responsibility, morally and legally, is that of all doctors—to diagnose and treat the sick. This implies attention to and provisions for the total care of the patient, including referrals and hospitalization when indicated, over-all care, and not only "psychological functioning."

As to training, candidates are selected on the basis of interest, past scholastic record, character and personality as determined by interviews and, in some schools, quite exhaustive tests. After graduation from medical school, one year's rotating internship in an approved hospital and three years' residence in approved hospitals and clinics are considered essential. To be certified as a psychiatrist, there is, in addition, a one-day comprehensive examination before a board in psychiatry and neurology. Training in psychoanalysis averages about three years of part-time study for those who wish this additional skill.

It is largely through teaching and research that the psychiatrist subjects his own and others' work to criticism and is in turn critically examined. It is unfortunate, in some instances, that time and previous training do not permit

careful objective evaluation of the work and formulation of new theories and changes in practice.

The psychiatrist, in understanding his own diagnostic and therapeutic role, establishes significant and coordinated functions with other professional groups. His work, at times, is made more effective as he opens the way for the social worker and the psychologist to contribute their skills to the total service needed by the patient. In psychiatric work with children, this coordinated service is both necessary and valuable. It is unfortunate that the term "ancillary" has been used to describe these functions of the nonmedical professions.

Summary

Psychotherapy is a process undertaken between a person with emotional disturbances and a specially trained professional person. In the medical profession, psychotherapy is the primary responsibility of the psychiatrist. Just as other medical specialists whose primary training is not psychotherapy may exert a psychotherapeutic influence while practicing their specialty, so other professional people, social workers, psychologists, clergymen, and vocational guidance workers, fill a similar need in a person whom they are helping to find a new balance between himself and his social milieu. The principle herein enunciated seems clear. The physician, while functioning within the sphere of his professional competence and realizing how he can help the patient with his emotional problems, can have an impact on the emotional life of the patient that is profound and enduring. But if he believes he must step out of his well-defined and accepted role in order to help the patient as a psychiatrist would, he only confuses himself and the patient.

These principles have a wide application to other professional disciplines that, within their work, have the opportunity and obligation to utilize sound psychological methods. The teacher with interest in and respect for children may well exercise a therapeutic influence of enduring value, but he does so as a teacher and not as a psychotherapist. Perhaps because psychiatry is a relative newcomer and because there seems to be an ever-increasing need for human understanding, this specialty may well be over-evaluated in its functioning and given a prestige that is not relevant to the circumstances.

A great deal of confusion and disruptive strivings for prestige can be diminished in the various fields of professional endeavor dealing with human beings if each group, trained in its own field, can realize the opportunity and full potentialities of its work. A true basis for integrating these skills is laid when there is respect on the part of all the professions for the differences and special qualities of each. There is then no destructive comparison of values and, while being different, each is as important as the other.

Remarks

Dr. Robert F. Solley (*St. Luke's Hospital, New York, N. Y.*): There is remarkably little that I can offer to clarify or improve on what has already been made quite clear. I can only reduce some of it to the focal point of the

internist as he views the patient with some reference to the aspects of problems involving the patient's emotional tensions or difficulties.

The patient is drawn to the doctor by various factors in his presenting discomforts and anxieties. His direction is more or less conditioned by influences, friends' opinions and so on. He is surrounded by family influences. Here is this mass of ideas, of conflicting experiences and influences and trauma, anxieties and distress, and the whole thing may be focused in one presenting symptom. The patient takes this great burden of difficulties to the doctor. Then you must consider the doctor's side. The doctor is in a hurry. He is busy. He has stubbed his toe or has had a ticket on the way to the office. It is a marvel to me that conversation between the patient and the doctor is intelligible during the first period of the interview, which is the nucleus of the first encounter between any physician and any patient. Preconceived notions must be overcome on the part of the physician and the patient, and nothing, I think, is more important than to allow enough time at the beginning, so that the patient becomes relaxed, so that he is able to dissolve some of the unhappy influences that accompanied him to the doctor's office, so that the physician can resolve some of his own difficulties and prejudices, so that he can overlook the hat that may look like a bird cage on top of the patient's head, or the twitch, or the anxiety that may arouse some corresponding anxiety in the doctor. If both can relax, if both can begin to feel that the atmosphere has the purpose of enabling the patient to communicate to the doctor all the difficulties that are the focal point of his coming, and if the doctor, on the receiving end, can allow that focal point to be the basis of the necessity for the patient's presence, a rapport can be established. Thereafter, any deviation from consideration of the presenting symptoms that may prove necessary will be accepted as relevant. As an outcome of these considerations, the physician may feel it to be outside of his capacity to deal with some or many of the patient's problems. Having established the rapport, however, and having made plain his understanding and willingness to appreciate the motives and the anxieties behind the initial encounter, there should be no difficulty in guiding the patient to further help in whatever area may be necessary.

Doctor William Cooper (*Hospital for Special Surgery, New York, N. Y.*): As an orthopedic surgeon, my concern is the correction of deformities of the bones and the joints. This is a rather prosaic specialty. What does it have to do with psychotherapy?

Like most medical specialists, orthopedists live in relative isolation, convinced that the greatest virtues reside in their own craft or their own specialty, and they feel little need to move outside of it. But as my own experience has grown, it has become more and more obvious to me, even in this limited field, that there is a direct, actual, and immediate relationship between the social adjustment of my patients and the actual progress which they make in relation to their orthopedic problems. Sometimes the problems can be identified even by me. They are problems in adjustment, some of which precede the patients' orthopedic difficulties, some of which come in the wake of them.

Without any professional competence outside my own specialty, it has nevertheless become evident to me that the progress and accomplishments of pa-

tients in orthopedics have been directly governed by the adequacy of their social adjustment. I long ago began to single out whole classes of patients on the basis of their adjustment and have been able to establish for myself, as an orthopedic surgeon, certain clinical categories into which these patients fall.

For the most part, I tend to deal with children, and what I say now applies particularly to children. I began to set down a classification of orthopedic disorders according to the adjustment of patients. The patient I most commonly see is the anxious patient, who presents obvious evidence of fear, fear that is generated by the medical disorder or by fear apart from it. I used to see parents again and again who would say, "My child would be fine if only he were not afraid." Such parents ascribed this fear to the child's infirmity, and often the fear was directly related to it. I used to see these children who looked afraid, afraid of falling, presumably because of a physical restriction. They were afraid of high places. They were also afraid of low places. They were afraid of having too few people around, or too many people. They were afraid of the absence of support. They were afraid of the light and of the dark. Because of these fears, they failed in physical accomplishment. It became obvious in many instances that the fearful, anxious patients with whom we were dealing were affected much more by their anxiety than by the physical limitations that led them to an orthopedic clinic.

The second category of patients is composed of those who, because of their disabilities, have had remarkable limitations of experience. Sometimes shame on the part of the parents has led them to hide away such children. I have seen children at the age of 10 who have not had the social experience of a normal one-year-old child. Such children do not represent isolated or rare examples. They are much too common. When these children, often brought up like Romulus, who was reared by the wolves, are occasionally brought out of the homes in which they have lived in isolation, they show at the age of 10, a severe and physical mental retardation that is more the result of the limitations of social experience than, actually, of physical disability.

A third group of patients includes children who are without motivation. Such children have parents who are too intelligent or not intelligent enough, who are overprotective, oversolicitous, and overaware of their child's disability and too eager to serve it. A child with such parents, even at the age of one month, learns to enjoy the special attention and service that it gets. Such a child enjoys the indolence in which it lives. Its physical disability is only a detail in a picture which often is interpreted solely as an orthopedic problem.

In contrast, there is another group of patients whose parents, instead of being oversolicitous, reject their children and accomplish the same general result as do the overprotective parents.

The next group is a special class exemplified by the child who, by having a limited physical disability, finds too much in the world for his limited ability. I remember one child whom we familiarly referred to in our clinic as the whirling dervish. She was unable to get about in a normal way, and used to get from room to room in our clinic by turning over rapidly on her side. She was always on the go, like a postencephalitic child that acts as if it were driven,

distracted by everything in the environment. In this instance, it was the physical restriction that created this peculiar pattern of activity.

Another group of patients we refer to as prima donnas, the children who deliberately try to escape from the real physical problems they have into an unreal world. They create a fictional world, which they inhabit as fictional characters, and they make no progress in the real world.

Obviously, the problems of all of these patients relate directly to the patient's environment and are a product of the home, *i.e.*, of the parent, of the school, and of local social conditions. To deal with these problems is not in the realm of my professional competence. These patients and their parents need a coherent and complete program for their guidance.

Even from such a practical and specialized viewpoint as that of orthopedic surgery, it seems clear to me if we were left with only one choice, it would perhaps be better to treat the parents of these children rather than the patients themselves.

To accomplish the type of guidance that is necessary, we have sought the advice and services of psychiatrists, of psychologists and, particularly, of social workers. Through them, we have attempted to understand the background against which the child with an orthopedic handicap has developed and the environment in which it lives. We have discovered, however, that it is not possible to transfer full responsibility for the guidance and care, outside the orthopedic aspects, to the psychiatrists, psychologists, and social workers, because these workers are too unfamiliar with the physical problem. Actually, the guidance has to stem from the orthopedic surgeon himself, the psychiatrist, the psychologist, and the social worker acting as consultants. In this way there develops a coherent relationship between the medical condition and the social and psychological complications that invariably occur in the patient having an orthopedic disability.

THE TRAINING OF PEDIATRICIANS IN THE HANDLING OF EMOTIONAL PROBLEMS

(Discussion of the Findings of the Medical Commission)

By T. F. McNair Scott
Children's Hospital, Philadelphia, Pa.

Let me begin with a direct quotation from Doctor Allen: "We have discussed the way in which the psychiatrist collaborates with the general physician or specialist if necessary—the reverse collaboration may be more difficult and sometimes not necessary even though there are emotional difficulties." It was about eight years ago that Doctor Allen's department gave impetus to the pediatricians at The Children's Hospital in Philadelphia, Pa., to take a fresh look at the care of children. The experiment in the teaching of residents to view the medical and psychological problems of the child as part of a total picture has been carried out by a member of his staff, Doctor John Rose.

From our experimental approach at the beginning, two important facts emerged: lectures gave no opportunity for the resident to handle his own fear of interpersonal involvement, and the administration procedures in the hospital made it virtually impossible for the resident to spend any time with the family of the patient. Virtually no attention was paid to the psychological effects on the child and on his parents of the illness and hospitalization. These were the days when it was a frequent complaint that so-and-so's mother was a problem parent and "psychiatric" consultations for her were clamorously demanded. Parents were largely regarded as foci of infection rather than foci of affection. Visiting hours were about once in two weeks. Parents were interviewed in the outpatient department (OPD), and then the child was whisked up to the ward to an isolated and hopefully aseptic environment. Contact between parent and child was by means of the telephone and, often, through a changing resident staff. On discharge, the child would be taken to the OPD and delivered, a comparative stranger, to the parents, who would be given a set of instructions by the resident then on duty.

Early attempts to liberalize visiting hours met with the standard objections. Little by little, however, visiting hours were extended to four days a week for one hour each day, and a list became available which provided unlimited visiting for selected patients. It was of extreme interest to the staff that, a year ago, after three to four years of the above schedule, the nursing staff initiated a request for further liberalization of visiting hours to the present system of everyday visiting from 2 to 6 P.M. At the same time, admission and discharge procedures were altered, so that now parents accompany their children to the wards, see the nurses, help put the child to bed if possible, and have an interview with the resident on the ward floor.

One aspect of the training problem took a long time to work out, but has now been functioning for the last two years. It had been the custom to have the work of the resident arranged in blocks of time on different services, with the result that patients and their parents often could not be followed by one

doctor. It is now mandatory for each first-year resident, in addition to his regular OPD service, to work in the OPD one-half day each week while he is on his other services in order to see the patients whom he had taken care of while they were in the hospital.

The problem of the resident's own attitude to his job and to his learning experience is more difficult and more subtle. While it was clear that skilled consultative help must be provided, the chief need was for a more constantly available consultative support to the resident. By 1951, a pediatrician who had been chief resident during one of the early years of this program had been trained, at his own request, to supervise the resident staff in giving advice and help in handling the emotional problems encountered. It is now required for the residents in the outpatient service to have one to two interviews weekly with the supervisory pediatrician. A psychiatric social worker and a psychologist are also employed in the teaching program, and an opportunity for consultative psychiatric referral is available.

Weekly conferences are held among the residents and the Department of Psychological Pediatrics. The character of these conferences has gradually changed from a rather formal discussion of topics by a member of the staff to the informal presentation of a case from the wards or from the OPD by one of the residents, followed by discussion. Recently, meetings have been instituted every two weeks that are consultations participated in by the residents and the assistant chief resident, one or more of the staff of the Department of Psychological Pediatrics, the head of social service, a psychologist, the girls in charge of leisure time activities, and all others concerned with the patients. All participate in the discussion and planning of the management of the patient. This program has proved a benign influence that pervades the entire institution.

The constant emphasis on the emotional attitudes of patients naturally influence, to some extent, the attitudes of the residents themselves toward each other and their work. The chief resident and his three assistant chiefs meet weekly with one of the members of the Department of Psychological Pediatrics, usually the chief, to discuss various problems that have arisen in regard to the management of those under them. The problems of interpersonal relations among the resident group are approached factually, and methods of dealing with them are suggested, with the result that frictions that had seemed inevitable to members who had formerly worked in other groups were noticeably absent. It may be merely that we are fortunate in our choice of personnel but, in any case, a mechanism has been set up for dealing with difficult situations as they arise.

It has clearly emerged, through the years, that the ups and downs of achievement depend on the interest and enthusiasm of the staff and, particularly, of the chief resident. Naturally, it is not always possible to pick an ideal chief resident. The measure of success in getting across these concepts to the new residents can be compared yearly with the attitude of this key figure. As the present chief resident put it to me about his own previous year's experience with his chief: "the hostility to the program sort of rubbed off on the rest of us." On the other hand, when the chief resident is interested and enthusiastic, the training of the residents proceeds much more quickly and effectively.

From my own observations and from discussion with others, it seems to me that one can expect it to take, on the average, about a year for a new resident to grasp the concepts of the program and to obtain some skill in the psychological understanding and handling of patients. This training in the total approach to the patient and his family is in contrast to the former experiences of residents from those institutions in which psychiatry, as taught, dealt in the main with psychotic states, and with the classification and handling of them. Gradually, with increasing experience, the men begin to appreciate the importance of the program to them as pediatricians, and they then eagerly seize every opportunity to improve their skills in dealing with children and their parents.

An interesting example of the different approach of a first-year and second-year resident, under this program, can be seen in the following case: A seven-year-old Negro girl was seen once in the OPD, when she was five years old, for abdominal pain and vomiting. She was brought in again in October of this year by the father for vague abdominal pain and vomiting. Nothing specific was found by the first-year resident, and she was given advice. She returned the next day much worse and was admitted by another first-year resident because of dehydration. This resident's impression was "gastroenteritis (a) viral, (b) salmonellosis." All the various laboratory studies were negative, she recovered, and was sent home in 10 days, without any note being made by the resident suggesting emotional involvement. She was all right for one week, then her symptoms returned and she was brought back to the clinic by her mother. This time she was seen by a second-year resident, one about whom, incidentally, we had wondered as to how much help the program had been to him. This man immediately inquired into possible psychologic causes for the girl's attacks and quickly found that there was a very difficult home situation with a tyrannical father and an accepting, passive mother. The patient was readmitted for immediate intravenous fluids and, this time, there were two and one-half pages of notes written by the first-year resident in charge of the ward on the "green sheet" for psychological observations, indicating referral of the mother to social service.

In summary, our experience at The Children's Hospital of Philadelphia suggests ways of training of pediatric residents to think in terms of the child and of its parents as individuals whose feelings are an important part of the total picture of the illness and that this is also important in the routine check-up. The suggested program requires: education of the senior staff so that they see the need for, and support, such a program; education of administrative and nursing personnel in humanizing hospital procedures to provide opportunity for the resident to have adequate contact with the parents of his patients and for follow-up; provision of a specially trained personnel for support of the residents, such personnel being drawn from the same professional background as the resident; and, finally, an opportunity for close contact with members of the ancillary services. It seems to be a fundamental point in the success of the program that the resident have his close personal contact with another pediatrician who may have special training but is not a psychiatrist.

Remarks

Doctor Samuel B. Gruze (*Department of Internal Medicine, Barnes Hospital, St. Louis, Mo.*): We start from the premise that medicine is really a form of applied biology and that, accordingly, we are interested in the relation between an individual organism, in our case a human organism, and its particular environment. This environment is a very elaborate thing. It includes things conventionally considered medical, such as bacteria and various chemical poisons, *etc.*, but it also includes a very complicated social and cultural environment in the form of people, symbols of people, language, *etc.* We understand that illness is really a way of describing a particular kind of interaction between an organism and this very elaborate constantly changing environment. We insist further that this illness is to be understood as only one event in the course of this organism's life and that, in order to understand the illness, we must place it against the background of a life history.

These reactions that we call illnesses are really various complicated changes in the way the individual person reacts to his environment, causing changes in the way his body functions. These altered functions, which constitute the illness, can be understood usually in psychological, physiological, biochemical, and other such terms.

Where does the understanding of psychological principles fit into this sort of framework? It does not really make any difference what the environmental stimulus is to which the patient is responding with illness in order to accept the fact that part of his response will be some sort of emotional response. Everyone recognizes this. In addition, there are special kinds of illnesses, special kinds of alterations in function that are related primarily to cultural and social stimuli.

Psychotherapy begins when the patient starts to see connections between relevant stimuli in his environment and some of the changes in his functions. Psychotherapy progresses when the patient becomes interested in trying to understand why he has a particular vulnerability or susceptibility to some of these stimuli. It seems to me that these two steps are appropriate for every physician to take without feeling that they are outside of his area in any way.

The additional step of helping the patient to modify the way he responds to some of these particular stimuli and to help him change his sensitivities is something that, I feel, every internist appropriately must consider his field of work. I believe that there is entirely too much splintering of responsibility for patients these days. There is too much of an idea that, since the internist is particularly interested in the physiological and chemical aspects of a case, he will deal with these phases; that the social worker will deal with cultural and social stimuli; and that the psychologist and the psychiatrist will deal with the psychological aspects of what is happening to the patient. I do not feel that this is the best way to help a patient. I think that an internist should understand exactly what he is trying to do; that, for example, he must help the patient first of all to identify the response that the patient is making to his environment. Is the response serious? Is it life-threatening? Is it something that is chronic and therefore must be taken into consideration as the

patient plans for his future? The internist must help the patient identify what are the relevant stimuli in his environment to which he is responding in this way. Sometimes, of course, the patient will not know. The doctor will know that he himself must look for certain microorganisms, but the patient will be able to help the doctor look for certain key figures in the patient's life. The doctor must then try to get the patient to understand why these particular stimuli are harmful to him and must help him to modify his response to them.

Are there any limits to the psychotherapy that an internist should apply? My feeling is that this is entirely an individual matter and not one of specialties. It seems to me that if an internist is interested (and I hope that, in future years, more and more internists will be interested), he should be prepared to treat any patient in so far as may be necessary, and I think this includes being able to deal with many of the problems that require psychotherapeutic skills.

INTERPROFESSIONAL RELATIONSHIPS

(Discussion of the Findings of the Medical Commission)

By Erich Lindemann
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I should like to try to summarize briefly and as systematically as possible the content of the preceding discussions on the medical report. Certain procedures, attitudes, and traditional routines are employed by members of a profession and by representatives of its various subspecialties to influence people coming to them for care. These processes are more nearly an account of beliefs and practices than a documented statement of the worth and effect of certain procedures. Realization of this fact is perhaps important for this whole field of counseling and psychotherapy, and to it, I think, should be added that of psychological first aid, as this field was often implied in the discussions.

If we wish to include all these phases in our discussion, we, as medical men, must find some way of establishing points of articulation with our ecclesiastical colleagues, our psychological colleagues, and our colleagues in social work. That could probably be done best by going back to Doctor Frank's reference to the charges given to the commission organizing the conference on which this monograph is based. Have the men and women on this commission answered the questions asked of them? These questions imply that there is a common body of thinking, perhaps knowledge, available to all people in those professions who, by means of the spoken word or by certain forms of behavior rather than by chemical or physical means, influence another human being so as to effect some change in him.

It seems to me that one thing certainly has happened, namely, the dispelling of certain stereotyped thoughts about what might be called psychotherapy. Psychotherapy cannot be understood if it is viewed as comprising an hour's interview in which certain skilled techniques are used to elicit information from the patient, to raise or reduce attending anxieties, to create insight, and to motivate the patient to a new course of action. Other elements must be taken into account. For example, all of the behavior of the caretaking person, in this case the medical doctor, has implications for the way the patient is motivated for good or ill, and also for the behavior of the people around him.

One might say that the most important ingredient of the medical profession's psychological operation is conveyed implicitly, rather than explicitly, to the receiving patient in the kind of care provided in the wards or in the operating room or in the office. It is this care that can reduce anxiety and provide an experience through which the patient's psychological needs may be met most adequately. This means that the ordinary events of the day-by-day medical care have to be scrutinized in the light of their probable effects on the patient and his family, especially as regards the way in which the care is experienced emotionally by them. Even being put to bed for several months for curing an orthopedic condition might have to be viewed as most dangerous to a patient

if he is one who is very much afraid of a state of passivity in which other people cater to him over an extended period.

So we have implicit psychological care in addition to psychotherapy as a formalized procedure. We have to ask ourselves, perhaps, in what way the doctor, as distinguished from the pastor, let us say, is the person of choice for people who want care. What are the kinds of people who are most suitable for medical psychotherapy rather than some other therapy? From our point of view, the medical man is likely to receive people who are afraid of dying, are afraid of impaired functioning, or are afraid of being very unhappy. The potential patient expects scientific competence, something of the ability of an engineer who takes a mechanism in hand and restores it to normal functioning. He demands from the doctor certain things; for example, that the communication between them be kept private. That provision is even legalized. The patient does not want the doctor to ask too many questions that he is not supposed to ask. He wants the doctor to confine himself to the complaint afflicting the patient. He would like the doctor not to become too well acquainted with him socially because the doctor might learn too much about him, and he would like to be able to discuss the doctor's medical opinion with him when the examinations are completed.

On his part, the doctor would like the patient to wish to get well. If the patient does not really desire to get well, the doctor may himself reach a high degree of anxiety or anger.

Doctor Talcott Parsons of Harvard University, who is a social scientist, has concerned himself with the role of the medical profession in comparison with that of other professions as perceived by most people. An implicit contract is set up between doctor and patient that sets certain limits beyond which the doctor cannot well go. For example, if the doctor starts talking about God and about the moral standards that the patient should observe, the modern patient will not like it. One might say that members of the medical profession, whether they like it or not, become involved in psychological and social problems but need to restrict themselves to treating, with scientific competence, the patient's malady. Medical men may also get into a human relationship in which they may feel, as did the young pediatrician cited by Doctor Scott, that possibly love is enough, *i.e.*, that human sympathy and support and understanding of the patient as a fellow human being in trouble may be the answer.

Such an attitude clearly is not the answer. There is indeed a body of knowledge which one must seek to assimilate. Now where is that body of knowledge? I think we have to admit that this knowledge, at this time, is transmitted by apprenticeship in a rather artistic way, and in a way that is very hard to document accurately. We psychiatrists speak in terms of personality theory to our friends, to the pediatrician, to the medical man, and the surgeon. We speak in terms of drives, motivations, frustrations, defense systems, *etc.* In many areas, we lack adequate proof for what we say, but we have highly plausible beliefs that we transmit to our colleagues in other fields, some of whom find these ideas useful.

I believe that our big problem is to bring about a cross-fertilization of the body of knowledge of our profession with the well-developed routines and practices based on the day-by-day experiences of those in allied professions. There has to be more of a meeting of minds, experience, and knowledge than we have had thus far.

THE FINDINGS OF THE COMMISSION IN PSYCHOLOGY*

Presented by Nevitt Sanford
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(1) *Introduction.* Psychotherapy, historically, has fallen in the realms of religion, philosophy, and education. If a person had a personal problem involving anxiety, conflict, or guilt, with respect to which he wished help, he would have gone, until approximately the time of Freud, to his religious mentor, secular teacher, or philosopher (or whatever the counterpart was for his social level). Thus the writers before Freud who treated most fully of psychology and the kinds of problems that bring most people to psychotherapists today were the philosophical and religious writers, such as Socrates, Augustine, Spinoza, Pascal, Kierkegaard, and Nietzsche.

Modern psychology has three main sources, one of which is the philosophical-ethical tradition mentioned above. During the 18th and 19th centuries, psychology was taught in the departments of philosophy and religion. The carry-over into modern psychology of this tradition of philosophical and ethical concern with man's problems and what to do about them is exemplified in such figures as William James (president of the American Psychological Association in 1894) and John Dewey (president of the same association in 1899).

The second source of modern American psychology has been the experimental psychophysiology and psychophysics that developed in Europe, particularly in Germany, after the middle of the last century. During the last decades of the 19th century, American psychologists were moved to declare the independence of their new science from philosophy and ethics. The experimental, objective study of behavior then became a dominant stream of psychology in America. From this source has derived the accent upon research methods and techniques that looms so large in the training and in the professional work of the psychologist. It has been the widely felt need to establish psychology as a science, perhaps, that has led, in some instances, to a preoccupation with methodology at the expense of concern with the theoretical significance and practical importance of psychological investigation.

The third main source of modern psychology was the hope and the expectation that a scientific approach would be an aid to the solution of problems in child training, education, personal adjustment, and group relations. This led to the development of a usable psychology of personality, major contributions being made by Freud, Jung, and others, who had a medical background. Although attempts systematically to apply psychology to practical human problems have been common since the beginning of this century, it is only within the last 15 years that applied psychology, particularly clinical psychology, has become the dominant branch of the whole discipline and that the major steps toward making a profession of the science of psychology have been taken.

Today, American psychologists exemplify, each in differing proportions, a combination of these three major trends. The profession of psychology has

* This paper, presented by Doctor Sanford at the conference on which this monograph is based, was written by him in collaboration with the other members of the Commission in Psychology.

stemmed mainly from the last trend, but interest in the scientific study of behavior remains a distinguishing characteristic of psychologists, and ethical values are still objects of lively, if sometimes suppressed, concern. It is interesting to note that even in the period of greatest concern with the purely scientific aspects of psychology, the motivations of individuals for entering the field were primarily to understand their own behavior and that of others, with consideration of human welfare just below the surface.

Thus it is that today the American Psychological Association is constituted "to advance psychology as a science, as a profession and as a means of promoting human welfare." This organization, with approximately 13,500 members, includes most of the qualified psychologists in this country. It is made up of 17 divisions designed to give recognition to the specialized interests of different psychologists. It publishes 10 psychological journals and an annual directory of members, maintains a central office with a staff of 25 in Washington, D. C., and is directly represented in 13 national organizations. Affiliated with the American Psychological Association are 4 regional and 41 state associations.

Of the psychologists in the national association, it is estimated that approximately 5,000 work primarily in the clinical area. Of these, almost half are employed in teaching and research in universities, the others working in hospitals, clinics, schools, correctional institutions, and private practice. It is estimated that about 400 psychologists give more or less full time to the private practice of psychotherapy or counseling. Of the clinical psychologists working in universities, many, perhaps the majority, perform some professional work with individuals on a part-time basis while, of those employed outside the university, many have opportunities for teaching in addition to their research, diagnostic testing, and psychotherapy. It must be noted, too, that many psychologists other than those specializing in the clinical area undertake, usually on a part-time basis, various forms of psychotherapy or counseling. Such psychologists might belong to one or another of the following divisions of the American Psychological Association: Childhood and Adolescence; Educational Psychology; Consulting Psychology; Counseling Psychology; School Psychologists; Maturity and Old Age.

The last 15 years have been a period of rapid and accelerating growth in the membership of the American Psychological Association. Thus in 1940 the membership was 2,739; in 1949, 6,500—approximately half of what it is at present. The task of organization and control during this period has been, and continues to be, a large and difficult one.

To accent the recency of professionalization in psychology, the following may be noted. The Committee on Training in Clinical Psychology, which had the task of setting up standards of training and initiating a program of visitation looking toward accreditation of graduate training programs, was set up in 1946. The American Board of Examiners in Professional Psychology, which issues diplomas as a means for designating to the public those members of the profession who, in the opinion of their peers, meet high standards of professional competence, was incorporated in 1947. The association's official code of ethics was provisionally approved by the Council of Representatives in 1952, and will again be submitted for final action in 1955.

It seems safe to say that the growth of professional psychology in recent years would not have occurred in the absence of widespread need for those services which the profession has to offer or without widespread public acceptance and support. To account for this awareness of need and for this acceptance and support—which is unique to this country—would require a thoroughgoing sociological and social-historical study. Probably such a study would lay heavy emphasis upon the selective service program in World War II which, for the first time, gave some conception of the true dimensions of the problem of psychological malfunctioning. Perhaps it would attach particular importance to the rise of totalitarian states, a phenomenon that has forced a reappraisal of man-in-society. No doubt it would stress the current crisis in politics, in economics, in moral values, and the passing of those programs of social reform that used to promise an end to discord and want. Finally, if it were well conceived, it would pay particular attention to those aspects of the American ethos which have always made for receptivity to empirical methods by which man might improve himself and his lot.

Psychologists of the older generations do not regard the professionalization of their science as an unmixed blessing. But they regard it as necessary and, by and large, they are prepared to make the required adjustments. They see the professionalization of psychology as an outgrowth of vast social changes that are not to be arrested or even altered in their course by committees, commissions, or legislatures, however numerous or wise these might be. But they see also the possibilities for the application of intelligence at least in the margin of events.

This report has been organized around the questions addressed to the several commissions by the Organizing Committee of the conference on which this monograph is based.

(2) *What kinds of persons with what kinds of problems does psychology seek to help by means of psychotherapy and counseling?* Psychology, the science of behavior, must seek to understand all problems that are psychological in nature. If it understands them, it can take practical steps to solve them. Sometimes it must seek to solve them in order to understand them.

It is very probable that at least some psychologists are undertaking to help with all the kinds of problems of psychological malfunctioning that people wish to talk over with a professional person. Included here, of course, are problems of the kinds commonly referred to as "neuroses" and "psychoses." But what kinds of problems a particular psychologist will undertake to solve depends on various important circumstances.

The "good" psychologist does only those kinds of work for which he has been trained. When he works with people whose social roles are defined in terms of their relations to some other profession that has a moral or legal responsibility for them, *e.g.*, pupil, student, inmate, probationer, or patient, he does so in collaboration with that profession, and in accordance with the rules that it is that profession's responsibility to apply. In these matters, most psychologists seem to adhere fairly closely to the expectations of their profession.

Psychologists specialize, in their training and in their later work, in a wide

variety of areas, *e.g.*, school adjustment problems, disturbances in young children, marital difficulties, delinquency, neurosis, psychosis.

Psychologists in private practice rarely work with extremely disturbed individuals. Actual practice varies widely with circumstances. If a psychologist is well established, he is guided by his interests, by his experience and past successes, by "the kind of person he likes to work with," by economic considerations, and so forth. If he is just getting started, unfortunately, he is likely to find himself burdened with unpromising referrals, so that he needs to know which to take and which to refer to someone else.

According to the code of ethics of the American Psychological Association, "the psychologist who engages in psychotherapy is obligated to make adequate provision for the diagnosis and treatment of medical problems arising in his work. To this end, psychologists doing psychotherapy may be expected to establish and maintain effective intercommunication with a psychologically-oriented physician." Once again, this commission believes that what *is* done follows rather closely what *should be* done. It is not only that we have some regard for the internalized morality of psychologists as a group, but we note that the costs of virtue in this matter are very moderate and the rewards of sin meager. It is not difficult to establish pleasant and rewarding working relationships with psychiatrists and other physicians, and it is a rare psychologist who, in private practice, is strongly tempted to work with borderline problems. Not infrequently, the psychologist in such practice, like the minister or the social worker, may be the first professional person to see a borderline case or a seriously disturbed person. Hence he is especially concerned with appraising the persons who come to him, referring some to other specialists when advisable. This does not mean that the psychologist may not later undertake psychotherapy with the borderline or seriously disturbed person. It means only that, if he does so, it is usually in accordance with the ethical requirement that it be in close collaboration with a psychiatrist. It is important to note, too, that the psychologist is not required by his code of ethics, nor does he find it wise, to refer for "diagnosis" *all* the people with whom he will work in psychotherapy. Many of his clients, perhaps the great majority, do not regard themselves as "sick" in the ordinary and outmoded sense of the word, nor are they so regarded by the psychologist. Should such a person become "sick" in the sense of being an immediate danger to himself and others during the course of his work with the psychologist, the latter normally, with the concurrence of the former, will make use of his relationship with a psychiatrist or psychologically-oriented physician.

The psychologist's judgment as to whether or not the problem presented to him falls within his field of competence is in no sense a medical diagnosis. Nor is the above intended to suggest that it is only in the case of the borderline problem or the seriously disturbed persons that the psychologist makes referrals to other specialists.

Whom the psychologist sees, and under what conditions, varies enormously from one geographical area to another. In big Eastern cities, particularly in those having a tradition of progressive psychiatry and social work, division of labor is the rule, the psychologist commonly specializing, for example, in work

with children or in work with character disorders. In smaller cities and in many areas of the West and middle West, where the public still first becomes aware of psychotherapy and counseling through the activities of psychologists connected with the universities, the psychologist is often the first professional to be seen by people suffering from all manner of difficulties.

It is important to note, too, wide variations from one community to another with respect to the climate of opinion respecting psychotherapy, psychology, psychiatry. The range is all the way from communities in which any kind of mental malfunctioning is still regarded as disgraceful, and in which a "nervous breakdown" is the only respectable form of difficulty, to communities or subcultures in which "being in psychotherapy" is definitely fashionable. Naturally, the kinds of problems with which the psychologist works vary widely with such circumstances. For example, he may work in a mental hygiene clinic in a city that gives little acceptance or support to psychology or psychiatry and where he sees only lower or lower-middle class people with gross or dramatic disturbances who have not the vaguest notion of what to expect or of what is expected of them, or he may be in private practice in a community where the level of psychological sophistication is high and where psychotherapy is looked upon not as a "cure" but as a positive "good."

Although, in the above, we have slipped into conventional terminology, it should be pointed out that there is a growing tendency in psychology to resist the type of Aristotelian thinking that goes into classifications of mental diseases and that leads to speaking of people "having" this or that disease. This commission applauds this trend. We also applaud what appears to be a growing accent upon a psychological approach to personal problems. This approach rests upon a psychology of personality development and seeks to conceptualize the goals of such development—differentiation, wholeness, autonomy, utilization of potentialities, and the like. Psychological well-being, from this point of view, does not mean absence of disease but rather a state of relatively advanced development. Psychological maladjustment is conceived of as relative failure with respect to the diverse goals of development. Psychological diagnosis—or, as we should prefer to say, psychological analysis of the problem—is an attempt to assess the developmental status of the individual with particular attention to the potentialities for and the obstacles to further growth, and to formulate in psychodynamic terms the reasons for this state of affairs. In his practice of psychotherapy, the psychologist seeks, most essentially, to further the growth of the individual, to help him to become what he can.

Unfortunately, we cannot say how common are these views among psychologists in general, but we call attention to the fact that the members of this commission, with their differing backgrounds, who are agreed in these views, are not unrepresentative of practicing psychologists. What is more unfortunate is that we cannot claim that an *adequate* theory of personality development has as yet been formulated or that adequate knowledge of the facts is about to be obtained.

It is encouraging to note, however, that progress is being made, through the efforts of an increasing number of psychologists and other scientists.

(3) *What are the methods and practices which psychology uses in seeking to help*

people? It must be admitted at the outset that the want of scientific knowledge in this area is so great that it is as yet virtually impossible to say with *precision* what any method or practice is. It is very difficult even to describe changes in personality, to say nothing of explaining them and gaining some measure of control over them. This is the major source of confusion and of controversy in this whole area. It is still possible for one psychotherapist to call by one name something that is not different functionally from what another psychotherapist calls by a different name. And two psychotherapists practicing under the same banner may be doing things that in their ultimate effects may be radically different.

In the present state of our knowledge, it is impossible to say that, for certain conditions, certain methods, in the hands of competent practitioners, will be effective. This is not to say that the picture is altogether black. Far from it. Wisdom, experience, art, and such science as we possess have been able to accomplish a great deal. Thousands of people have been helped by psychotherapy. Indeed, it is very probable that the vast majority of people who have entered psychotherapy have somehow been helped. And this is just the point. Every psychotherapist, whatever his methods or techniques, is able to report improvements. But to say with assurance what activities produced which effects—this is a very difficult matter. It is not that we are completely in the dark. The weight of evidence certainly favors certain principles more than others. But ignorance is still so great that we need not be surprised if dogmatism, unwarranted claims, even adherence to mythology, are sometimes displayed by practitioners in the field.

Each of the more or less distinguishable kinds of psychotherapy and counseling, such as client-centered psychotherapy, psychoanalytic psychotherapy, psychoanalysis, group psychotherapy of various kinds, is practiced by some psychologists. There is variation with training, theoretical position, the conceived requirements of the case, with interest. The most essential fact, which proceeds from the state of affairs described above, is that there is no particular psychotherapeutic procedure or technique that belongs solely to the domain of professional psychology and for which only psychologists are trained. What distinguishes the professional work of the psychologist are not particular procedures or techniques but certain general characteristics of his approach to human problems.

Of these characteristics, the most important is the orientation toward research. The psychologist is trained as a scientist, and he does not give up his scientific attitude, his scientific spirit, when he finds himself face to face with a practical problem.

There is a common notion of a categorical distinction between "cold" science and the "warm" human relating that moves psychotherapy forward. Let it be said at once that this distinction is not only false but mischievous. Actually, research on human problems, and activity designed to promote the welfare of the individual objects of that research, can be separated only arbitrarily. Anyone who undertakes an intensive investigation of personality dynamics—by means of interviews, let us say—has to reckon with the likelihood that his subjects will change as a result of being studied. He cannot escape

responsibility for these changes, but must take steps to insure that the changes are helpful, or at least not harmful, to the individuals involved. On the other hand, it would appear that the first task of the psychotherapist or counselor is to understand as well as possible the behavior of the people with whom he works. With due weight given to intuition and empathy, the fact remains that this understanding is of the same kind as that involved in achieving knowledge of people in general. It is no accident that the insights and hypotheses that form the core of contemporary theory of personality were contributed by scientists who were heavily engaged in psychotherapy. And this is why the clinical psychologist today considers himself under an obligation, as a scientist, to find opportunities for practical work with people. There is nothing to suggest that an orientation to inquiry and understanding interferes with an orientation to helpfulness. Indeed, the two orientations may be regarded as aspects of the same humane enterprise.

The research orientation has other implications for the psychologist, who cannot help but be impressed, first of all, by the lack of scientific knowledge respecting psychodiagnosis and psychotherapy. Hence, in the best case, he approaches his professional work with appropriate humility. This means that he feels the necessity for sharing his ignorance and his hunches with colleagues, for communication through teaching and being taught, and for supervision and being supervised. An objection to the "isolated" practice of psychotherapy thus becomes apparent. We would distinguish between private practice and isolated practice: the latter is not the most favorable circumstance for carrying on the scientific activities of a psychologist.

The approach of the psychologist is further distinguished by the way he conceives of the nature of psychotherapy and the way he conceives of his relations with the people he seeks to help.

In the present state of our knowledge, it is probably impossible to define psychotherapy in a way that will be generally acceptable, even among psychologists. But it is possible, perhaps, to say certain things *about* psychotherapy that will be agreed with by most of the psychologists who practice it. The purpose of psychotherapy is to help the individual achieve fuller development. What can be accomplished by giving advice, offering support, assuming any kind of direction of an individual's life, is severely limited. The psychotherapist cannot put something into an adult personality that was left out in the first place. He can, however, create conditions under which the individual's inherent tendencies to growth have a fresh opportunity to express themselves. These conditions are, essentially, an understanding, in the terms of systematic psychology, of the client and his problems, and the establishment of a relationship that involves the client emotionally and opens him to new experience. Under these conditions, the psychotherapist may offer comments and interpretations designed to help reveal the client to himself and to permit him to see his relationships to the world in new perspective. Such understanding on the part of a client may bring about a restructuring of his internal organization and of his system of interpersonal relationships so that obstacles to growth are removed and unused potentials are released.

Education, particularly when it is aimed at changing attitudes, also seeks

to create conditions favorable to growth. It makes use even of the affective relationship of the student to the teacher. But, unlike psychotherapy, education does not proceed on the basis of a diagnostic study of the individual personality but rather in accordance with assumptions about what favors growth in general. Education does not use the affective relationships of student to teacher as the subject of interpretations designed to increase self-insight. It uses them, rather, as sources of motivation and inspiration. It is interesting to note, however, that, just as some procedures that have been called group psychotherapy do not differ essentially from education, there is a tendency in education to move in the direction of group psychotherapy, using for teaching purposes the emotional processes operating in the teacher-class situation.

Psychotherapy, which is concerned with changing the internal organization of the person, differs rather sharply from those forms of social case work that seek to improve the individual's well-being by modifying his external environment, and from those forms of counseling which, without going into the inner life of the individual, put the expert's knowledge and wisdom at the disposal of the individual's attempts to deal intelligently and realistically with his environment.

Although, as indicated above, the psychologist frequently works with patients in hospitals or clinics, he often undertakes psychotherapy with clients in settings that are not medical. His relations with a client are different from those that ordinarily hold for a physician and his patient. The psychologist, unlike the physician, does not assume responsibility for the total well-being of of the client, nor does he claim the privileges that go with such responsibility. The client who enters psychotherapy in a nonmedical setting, unless the psychologist has been sadly mistaken in his judgment, is a relatively autonomous person, able more or less to make his own decisions and to govern his own life. He is not required to surrender any of this autonomy. Since the psychotherapist does not undertake to participate in the direction of such a client's life, it is quite possible for the latter to enter into relations with members of other professions—his physician, his dentist, his minister, his lawyer—while undergoing psychotherapy. Communication between the psychotherapist and these other professional people is with the client's consent and understanding. Not only must he know that discussion with other professionals occurs, he must know what is discussed so that he may participate in any decisions affecting him. It is true that the development of a psychotherapeutic relationship of the kind outlined above leads to a client's becoming, from time to time, highly dependent upon his psychotherapist. But the psychotherapist may use the client's dependence for no purpose other than to help him become more aware of his own functioning and, hence, to achieve a higher degree of autonomy.

The type of psychotherapeutic work just described is appropriate only if two major conditions are met: first, that the work of the psychotherapist is directed only to the client's *psychological* problems; and, second, that the client be an autonomous person. The possibility that the client may have, at the beginning, or develop during the course of psychotherapy, others kinds of problems, for example, medical ones, is real. It is mainly for this reason that the

psychologist is enjoined by his code of ethics to know the resources of the community and to maintain effective relationships with other professions, so that he may assist a client in obtaining the help that he needs. But for the psychologist to render such help without stepping out of his psychotherapeutic role, and for him to know when he must surrender the role, these are very different problems for which no general solutions have been found. The case of the psychologist is not different, however, from that of any other psychotherapist. The skill and judgment of the individual practitioner is at the present time determining.

How disturbed, or impaired with respect to psychological growth, a client may be and still function as an autonomous person is another very difficult question with respect to which expert opinion varies widely. The seriousness of a case from the point of view of social consequences is by no means the same thing as seriousness from the point of view of the individual's ultimate fate. Neither kind of seriousness is very closely related to the difficulty of bringing about change. One may hope that continuing research will ultimately supply the needed answers.

(4) *What kind of training is now being provided to prepare psychologists for the practice of psychotherapy and counseling?* At the present time, virtually all psychologists entering this field have obtained the Ph.D. degree, after four or more years of graduate training. The first two years are devoted to general psychology, including history, experimental and physiological, facts and theories of personality dynamics, research design, statistics. In the last two years, the candidate writes a research thesis, receives specialized training in clinical procedures and techniques, and serves a year of supervised internship in a clinic or mental hospital.

The general quality of the training varies from one institution to another, a matter that depends most heavily—where psychotherapy and counseling are concerned—upon the type of supervision that is available.

The Education and Training Board of the American Psychological Association has an Evaluation Committee that visits those university psychology departments requesting evaluation, and publishes a list of departments approved for doctoral training in clinical psychology. A regrettable feature of this necessary device, of course, is that it tends to promote standardization or crystallization where further exploration and pursuit of individualistic programs would often be desirable.

Various postdoctoral training opportunities, including summer institutes, are available to the prospective psychotherapist or counselor.

The American Psychological Association does not consider that the Ph.D. in clinical psychology is by itself evidence of competence to work independently as a psychotherapist. Nor does the individual psychologist concerned harbor this supposition. The latter is likely to arrange for further training in institutes, or for further supervision in hospitals or clinics—he is likely to work on either a full- or part-time basis—or on a private basis. A need for more facilities for such advanced training, and for improvement in the quality is widely felt among psychologists, and much effort is directed to promoting these ends.

It is an official policy of the Clinical Division of the American Psychological Association that "anyone who engages in the unsupervised practice of counseling or psychotherapy should be aware of his own possible inadequacies, blind spots, and psychological traumatizations. To this end, it is desirable that he experience some type of personal counseling or psychotherapy himself with a clinical psychologist or other professional worker of recognized standing."

Many clinical psychologists have undergone psychoanalysis or some other form of depth psychotherapy.

It should be noted that the above program of training in clinical psychology is not intended primarily as preparation for the private practice of psychotherapy or counseling. It aims at training that is sufficiently fundamental so that its recipient may go on to make contributions in research, in diagnostic work, in teaching as well as in psychotherapy, and in counseling. Postdoctoral training is regarded as desirable for specialization in any one of these areas and especially so in the case of the last.

Many clinical psychologists engage in all four of these kinds of activity. The great majority engage in at least two of them.

Some psychologists now practicing psychotherapy took the Ph.D. in some field of psychology other than clinical. Their training for their chosen specialty was almost entirely postgraduate. The tendency and expectation now, however, is that the Ph.D. be specifically in clinical psychology.

(5) *The selection of persons for training.* All departments of psychology with approved programs of training in clinical psychology are able to select from among numerous candidates for graduate training. Selection, in this first instance, is for training in psychology—not for training in psychotherapy, or even in clinical psychology. The accent is on intelligence, promise of scholarly attainment, and personal soundness.

Specialization in clinical psychology or "entering into the clinical program" ordinarily does not become an issue until the second year of graduate school. Here departments differ widely one from another. Some make a special effort to select on the basis of judgment regarding special aptitudes for clinical psychology, others permit self-selection more or less to hold sway.

There is lively controversy in this whole area. It is sometimes argued that the skills and dispositions required for effective work with individuals have little or nothing in common with those required to perform psychological experiments or statistical manipulation. On the other hand, there is impressive evidence that abilities tend to be positively correlated. Psychology does not argue that the Ph.D. program in clinical psychology is the best basic training for psychotherapy or counseling, or that the practice of psychotherapy and counseling ought to be limited to people who have had psychological training. It considers that adequate psychotherapy and counseling are offered by members of four or five other professions—even, sometimes, by people who have had relatively little professional training specifically concerned with psychotherapy. But psychology is concerned with the advancement and application of *scientific* knowledge about people and, to this end, it proposes to limit membership in its body to persons who will accept the discipline thus implied.

There is evidence that motives for entering the field of clinical psychology are changing. Not many years ago, the student interested in clinical problems was likely to be an adventurous spirit who did not mind being something of a misfit in the psychology department. His motives, commonly, were highly "internal" if not idiosyncratic. He had no way of knowing where he would end up. Today a person may enter clinical psychology in about the same way that one enters any of the established professions. He is likely to have very clear notions of what a clinical psychologist is and does, and be guided by the deliberate weighing of externally determined advantages and disadvantages. We are face to face with the old dilemma, how to have standardization without loss of originality, and how to establish high canons of training without excluding the gifted person who doesn't necessarily fit the standards. There is something to be said in this respect for the good old days.

There is evidence that some persons enter the field because they unconsciously want to become like a psychiatrist, and mistakenly imagine that training in clinical psychology will be a short cut to this end. It appears also that, among some younger clinical psychologists, there is a certain amount of unwitting imitation of medical assumptions and medical ways even while there is overt rejection of certain of psychiatry's ideological commitments that helps to cover up the silent identification. But there is also increasing awareness of these tendencies, and the hope that they may be brought under control.

(6) *Collaboration of psychology and other professions.* By far the majority of psychologists who perform psychotherapy do so in hospitals or clinics, where their collaboration with medicine and social work is very close. Hospitals are medical institutions, and psychologists who work there usually have little difficulty in adapting themselves to procedures established by the medical administration.

The roles of psychologists in mental hospitals vary widely from one institution to another. In some hospitals, the psychologist is permitted to do no psychotherapy; in many, he takes very considerable part in this service; in still others, some psychotherapy is his major contribution. It is our impression that, generally, the function of psychotherapy is not denied the psychologist, but the screening procedures for determining who shall do psychotherapy are somewhat tighter for psychologists than for physicians. Many psychologists would agree with the recently enunciated policy of the Veterans Administration, which, in describing the work of psychologists in VA hospitals, gives higher priority to diagnosis, research, and training than to psychotherapy. This commission, of course, stresses that psychotherapy is not only necessary to, but integral with, effective research.

Mental hygiene or child guidance clinics tend to be less rigorously medical. The director is not necessarily a psychiatrist. In some states, he may be a psychologist, a social worker, or a physician. In such clinics, members of the several professions characteristically work as a team.

There are group practices in which various combinations of professional workers function on an equalitarian basis. There are practices in which psychologists and nonpsychiatric medical men work together.

The psychologist engaged in the private practice of psychotherapy usually

maintains collaborative relationships with a number of psychiatric and general practitioners of medicine. It may be well to quote here from the official policy of the American Psychological Association as adopted in 1953:

"*Principle 5.4.* Since society endorses independent *private practice* of the professions, the profession of psychology regards it as appropriate for its members to choose this mode of practice, providing that they are properly qualified.

"*Principle 5.41.* Recognizing that independent private practice, whether in clinical, counseling, or industrial pyschology, involves the assumption of grave professional responsibilities requiring both high technical competence and mature judgment, the profession of psychology will support a member's decision to elect this mode of practice only if, in the judgment of his peers, he is *qualified by training, experience, maturity, and attitudes* to hold himself forth to the public as a qualified psychologist.

"*Principle 5.42.* Since the practice of psychology in institutional settings or under qualified supervision or in team or group practice (whether supported by a community or by private fees) encourages collaborative decisions and provides for certain social controls, such practice may be appropriately engaged in by psychologists who do not yet meet the high qualifications expected of persons for independent practice.

"*Principle 5.43.* Individuals electing to function independently, not as psychologists but in more limited roles where they do not assume the responsibilities for professional decisions, may also appropriately do so with lesser qualifications than are expected of those who hold themselves forth as qualified psychologists. Examples of such persons are those trained as teachers of remedial reading, speech correctionists, or specialists in a particular testing technique. Such individuals should confine their professional services to those functions for which they are well qualified by training and experience and refrain from holding themselves forth as psychologists.

"*Principle 5.44.* The profession of psychology approves the practice of psychotherapy by psychologists only if it meets conditions of genuine collaboration with physicians most qualified to deal with the borderline problems which occur (*e.g.*, differential diagnosis, intercurrent organic diseases, psychosomatic problems). Such collaboration is not necessarily indicated in remedial teaching or in vocational and educational counseling."

The possibility of a gap between official policy and actual practices of psychologists must be considered again. It is very likely that there are some psychologists who do not live up to the expectations just enunciated. We can say only that the profession is earnestly striving to bring practice up to the levels described.

There is at present strong cooperation between psychiatry and psychology in the training of clinical psychologists. Almost invariably, the required internship in clinical psychology is taken in a medical setting, where the intern receives instruction from psychiatrists and learns methods of establishing and maintaining interprofessional relationships. It is common also for psychologists to contribute to the training of residents in psychiatry.

But the clinical psychologist receives the bulk of his training in the graduate school of a university, where he learns to think of mental health as a community

problem and as a social problem, and to see it in a context with general human relations. He thus early and naturally enters into communication and collaboration with other scientists—primarily sociologists and anthropologists—and with other persons in training for professional work in human relations, for example, in social welfare, or in education.

Many psychologists who practice psychotherapy and/or counseling are, at the same time, members of university faculties. Many of their patients or clients are college or university students, a circumstance that involves working relationships with various officers of such an institution.

In general, smooth and effective collaboration is likely to occur when psychiatrists and psychologists together confront an actual job. Collaboration has often been particularly satisfying, on both sides, when members of the professions have worked together in research undertakings. The power struggle between these two professions is carried on mainly at the level of official resolutions or pronouncements.

Psychologists, in general, welcome collaboration with psychiatry, but it is important to note that official descriptions of the profession do not recognize the requirement of psychiatric supervision as such. The requirement, rather, is that the clinical psychologist in training receive supervision by the most competent and experienced persons available. Often, of course, such persons are psychiatrists. Supervision, as contrasted with collaboration, refers to a need of the young and inexperienced practitioner, whether he be a psychologist, social worker, or psychiatrist. Supervision has no place in a consideration of the relations of one profession to another.

(7) *Social expectations and sanctions.* A profession best maintains genuine and effective control over its members by setting up and enforcing its own standards in respect to training and practice. Legislation, however, may serve to designate for the public those practitioners who are approved by the profession at a minimum standard of quality. The American Psychological Association favors, as the most feasible and desirable method for protecting the public from quackery, legislation that will permit only properly qualified persons to call themselves psychologists. Such legislation makes it possible for the profession to protect its own name, and it is an aid to the maintenance of standards. The association does not favor the type of licensing bill that restricts the performance of certain activities to psychologists alone.

Seven states have laws pertaining to the practice of psychology and, in other states, legislation is pending. In all of these cases, with one possible exception, the essential feature of the law is that it establishes standards for the use of the name "psychologist," and that psychology is not defined in such a way as to exclude other professions from engaging in it.

At its meeting in September 1953, the Council of Representatives of the American Psychological Association adopted the following statements of policy concerning legislation:

"Psychology accepts the responsibility for (a) establishing meaningful standards of professional competence, (b) designating to the public those members of the profession who have met these standards, and (c) effectively informing the public concerning the meaning of the established standards of competence.

"In performing its applied functions, either alone or in association with other professions, psychology accepts the responsibility for adopting every feasible means to protect the public from the incompetent or unwise application of psychological knowledge and techniques.

"The professional services rendered by psychologists vary greatly in their distinctiveness. Some are rarely carried out by non-psychologists; others are fully shared with several other professional groups. Public welfare is advanced by the competent performance of socially useful services by a number of professions. Psychology believes it undesirable to attempt to control the practice of all psychological functions by restricting them to members of any single profession *except insofar as it can be clearly demonstrated that such restriction is necessary for the protection of the public.* Psychology, therefore, does not favor narrowly restrictive legislation, which provides that only psychologists (or teachers, or physicians, *etc.*) may engage in certain applications of psychological knowledge and techniques."

Psychologists, in seeking legislation, would much prefer to work for laws that have the approval of psychiatrists and of the medical profession. Most psychologists have felt that their future, as a science and profession, has been seriously threatened in those states in which legislation introduced to revise medical practices has tended to define psychotherapy as a branch of medicine. This insecurity has had several harmful effects. It has interfered with the day-to-day professional work of psychologists; caused reappraisals of long-term research plans; and, understandably, promoted among some psychologists the defensive reactions of counter-phobia; namely, pushing too rapidly for professionalization, and identification with the aggressor, *i.e.*, unconscious imitation of the psychiatric approach rather than sticking to uniquely psychological functions. One helpful by-product of this insecurity, perhaps, has been that it has stimulated psychologists to greater efforts to define their positive psychological methods and to develop their ethics as a profession.

(8) *By what methods and techniques does the profession of psychology critically examine its own work and seek to advance its professional competence?* The above references to the American Psychological Association's Code of Ethics, to statements of its Committee on Training in Clinical Psychology, and to the American Board of Examiners in Professional Psychology go a considerable way toward answering this question. Perhaps a further word about the work of this board should be added here. The following passage is from an official policy statement of the association as adopted in September 1953.

"The most tangible evidence of such endorsement by peers is possession of a diploma issued by the American Board of Examiners in Professional Psychology, a diploma issued only after an intensive evaluation of a psychologist's training, experience, reputation and professional attitudes in addition to written and oral examinations. Other current symbols of achievement or status (*e.g.*, the possession of an M.A. or Ph.D. degree, membership in the APA or its divisions, previous experience in private practice, and certificate or license of a state) do not guarantee the degree of professional competence deemed necessary for fully independent practice.

"Some psychologists not holding an ABEPP diploma may admittedly be fully

competent to assume the responsibilities of independent practice. However, psychologists electing to enter independent private practice without a certifying diploma must do so without the expectation that their colleagues or their professional associations will defend the propriety of their decision."

In answering this question further we may recall the paragraphs cited earlier in this report concerning the research attitude of the psychologist—the attitude that it is second nature to share ignorance and hunches, to communicate through teaching and being taught, through supervising and being supervised. We may conclude our answer to the question—and to this report—with another reference to the most essential and unique function of the psychologist; that is, research into behavior. Improvement in the practice of psychotherapy and counseling depends, in a most essential way, upon increased knowledge of their nature, knowledge of what methods bring what results with what problems. In the attack upon this fundamental psychological question, the major contributions are being made today by psychologists.

THE PSYCHOLOGIST AS SCIENTIST

(Discussion of the Findings of the Psychology Commission)

By Robert W. White
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The points in the report that I wish particularly to underline concern the psychologist as a scientist. The psychologist is trained first and foremost as a scientist, and he does not give up his scientific attitudes, his scientific spirit, when he finds himself face to face with a practical problem.

Doctor Lindemann, in his discussion, wondered if the psychologists, in their report, would explain the processes involved in interviewing and in psychotherapy. He wondered further if we would give some suggestion of basic underlying knowledge that we might call the scientific foundation for the practice of psychotherapy. I think we should take up this challenge, not with the feeling that today we know how to answer these questions, but rather in the spirit that it is very much our job to move in the direction of answering them.

One of the statements in the report calls attention to the fact that the psychologist is a student of the growth of personality. This involves being a student of psychodynamics, of the impulses, fantasies, unconscious processes, defenses, *etc.* upon which Freud first opened the door. The psychologist is certainly a student of psychodynamics, but he must also be a student of more than that. I am going to suggest that psychodynamics is not enough as a foundation for the understanding of either human nature in general or of psychotherapy in particular. To illustrate this suggestion, let me mention one particular topic in which the addition of knowledge from other than therapeutic fields greatly increases the understanding of a growth process. From Freud we have received the conception of the superego, the irrational conscience starting in childhood. It is a very important key concept in psychodynamics, but this same problem has been approached from another source in an entirely different way. What I refer to is the work of Jean Piaget on children's moral judgments. In his studies this investigator takes the position that the child perceives moral questions in a quite primitive fashion as compared to the adult, and that only gradually, in middle childhood, does he begin to grasp what we may call a mature conception of morality. This is because of the child's limited cognitive development, a limited development in his understanding of what is taking place around him. This is the kind of knowledge, it seems to me, that the profession of psychology should add to the study of psychodynamics.

There are other things besides psychodynamics. There are such questions as level of development, cognitive development, perceptual development, comprehension, and conceptual development that need to be closely tied in with the whole idea of psychodynamics before we can have a full, over-all understanding of the nature of human growth.

Going on to a somewhat broader consideration of this problem: in the

thinking we have done so far about development, we have been at a disadvantage in that most of our leading insights have come from psychotherapeutic work. This may seem an ungrateful remark. Certainly without the insights that have come from psychotherapeutic work, psychology would be far less advanced than it is today. It is my feeling, however, that the future advance of understanding of human growth will come perhaps less and less from the psychotherapist who has opened all these vistas, and more and more from the student of individual development, who is able to operate in a more empirical, experimental, and controlled way.

In our present thinking, for example, we have an idea about normal development and the normal personality, but our normal person is largely a myth, or at least largely an inference from what we see in people who are sick. The normal person is conceived, we might say, by extrapolation from the sick people and not by any direct study of the normal person himself. The normal and mentally healthy man of today, in this image, rises brightly in the morning after a sleep undisturbed by anxiety. He has before him an extremely busy schedule because he is, after all, a balanced personality and therefore not neurotically overcommitted to one single goal. He passes through his busy day in a highly extroverted manner, for it is not characteristic of him to have any schizoid craving for solitude. So free is he from neurotic blocks and obsessive anxieties that this busy day does not exhaust his energies in the least and, by evening, he is all prepared to furnish further proofs that he has reached genital primacy. I have a good deal of difficulty in placing this normal person in any occupational role. It seems that he must be, perhaps, a traveling salesman who rises each morning with fresh territories to conquer and an unbounded enthusiasm for what he is going to do.

Now this picture, of course, vanishes into thin air the moment one starts to study even one single so-called normal individual. None of the persons thus studied turns out to be what we might call a "psychiatric clear" in the sense that he has no emotional problems, in the sense that there are no psychodynamic complications working within him. Such persons often do not seem to come from mentally hygienic homes. Yet we have in our thinking no proper way of explaining the thing that we all recognize to be true, namely, that a person may come from an unhygienic home, perhaps a broken home, with rejecting parents, with everything stacked against him, with all kinds of psychodynamic problems, and finally without any therapeutic help he nevertheless becomes a member of The New York Academy of Sciences and makes a great contribution to human welfare. In other words, we have no satisfactory base lines of normal development against which we can build this fundamental science that is going to be applied to psychotherapy. I think that this is one of the most real and serious roadblocks in the building of our science today. It is also one of the most serious roadblocks in our public relations, and I mean this for all professions that collaborated in the conference on which this monograph is based. What we are able to give out to the public in the way of advice on how to rear children, for example, is all fraught with images of the harm that can be done, the havoc that only we professionals can rectify.

So we entrust the task of developing healthy, anxiety-free children to parents whom we have utterly terrified by the instruction that we have given them.

Of whom, of what group, can we ask that research in normal development be carried on? In the future, I think, it is to the profession of psychology that we shall have to turn for the bulk of the advancement of understanding about development that, eventually, will make a science for psychotherapy. We cannot reasonably ask this from a profession that is dedicated to the care of the sick. We cannot reasonably ask it from a profession that dedicates itself to the cure of social ills, or to the cure of ills of the soul. The one profession from which we can ask this is the one in which research and the attitude of the scientist are the basic important ingredients of the training program. This is not to suggest that all the work, and certainly not that all the inspiration, will come from one group, but if there is to be any division of labor on this task, then it is the psychologist who should be assigned heavy duty on this front of scientific discovery.

EMERGING CONCEPTS THAT AFFECT INTERPROFESSIONAL ALIGNMENTS IN PSYCHOLOGY

(Discussion of the Findings of the Psychology Commission)

By George A. Kelly
Ohio State University, Columbus, Ohio

In discussing this paper, I should like to do three things. Some points I should like to underscore to make sure their significance is not overlooked. Then I should like to add documentation to others. Finally, I should like to draw certain generalizations from the report that seem to indicate how, in the next decade, psychotherapy will most certainly be increasingly developed and practiced by psychologists.

Psychology as a discipline brings to our civilized society certain important new concepts. Some of these, as the report suggests, have ancient roots in the "tradition of philosophical and ethical concern with man's problems." Some, as the report also points out, are rooted in the experimentalism of the late 19th century. But it is proper to say that none of the important new concepts that psychology is now bringing into our public life is rooted in the medical tradition. Indeed, many of the convictions of psychologists are so antithetical to medical traditions and to medical concepts of the necessary relationship between a professional man and his client that a vast chasm has opened up between psychology and medicine. That chasm is threatening now to engulf both professions in a chaotic dispute.

This is a strong and revolutionary statement. One who hears it for the first time will immediately find his thoughts turning to the significant psychological contributions of Freud, Jung, Adler, and others, many of them physicians. But these were the men who broke with the medical tradition of their times, and the essential cleavage between what they sought to grasp and what modern medicine still believes is as wide and clean as it ever was. Psychoanalysis exists in the framework of organized medicine today only as another of those paradoxes that arise when an insecure new group finds it expedient to ally itself with a powerful agency whose views it secretly abhors. The strange alliance is as puzzling to most legitimate physicians as it is to psychologists. One cannot help wondering if any profession, thus misallied, will ever produce a whole generation of thinkers whose thoughts will be as unfettered by medical tradition as Freud's were.

Thus the report we have laid before us acknowledges the indebtedness of modern psychology to the theoretical and technical contributions of Freud, Jung, and others, but it claims no specific roots in the medical tradition. Whether good or ill, this is correct. Perhaps the authors of the report would not have emphasized this cleavage as sharply as I have, but there it is, and it is one which is often recognized and genuinely respected by nonpsychiatric medical men with whom psychologists frequently collaborate so successfully.

So, as the report points out, the new concepts of psychology have roots, roots in philosophy and ethics, roots in experimental research, and roots among

those individuals who have had the courage and intellectual vigor to break out of the biological framework of medical thinking. Most psychologists are only too happy to acknowledge some spiritual kinship with these men, and they wish that the field of psychotherapy today might be more widely occupied by men of equally venturesome spirit.

Briefly, what are the new concepts that psychology brings into our society? Systematic empiricism is one. When the report speaks of empiricism, experimental research, and the outright emphasis that therapy-practicing psychologists place upon the logical processes of science, it is not referring to any fly-by-night opportunistic clinical intuition. We note, for example, the following statement in the report: "There is a common notion of a categorical distinction between 'cold' science and the 'warm' human relating that moves psychotherapy forward. Let it be said at once that this distinction is not only false but mischievous."

This statement of the commission carries a considerable freight of meaning. As long as the biological point of view was considered to be the essential model of all behavioral science there was, indeed, an essential and categorical distinction between what could be conceived as science and what was viewed as a matter of warm human relationships. A professional man could establish warm human relationships only by laying aside his biological science for the moment. Biology quite obviously provided no framework for understanding such phenomena as human relationships. This laying aside of scientific outlook in which he has been disciplined is what many a skillful physician has learned to do after he has got away from the environment of the medical school. Often he does it with a guilty conscience; he knows he is not being scientific. Yet most of us here would say that it is a credit to the medical profession that so many of them have discovered when to stop being the kind of biological scientists they were trained to be, and have struck up warm, though unscientific, human relationships with their patients. And it is also a credit to the vast majority of practitioners that, when they have done so, they have made no pretense of being scientific. They have admittedly played by ear.

Now the science of biology, upon which medical practice is based, is a marvelous system of human thought. It has served humanity well and it will, no doubt, continue to make great strides into the future. Let us not, therefore, underestimate its stature. But biology is not a magic mirror in which human behavior can be seen in all its true aspects. There are other scientific ways of examining human behavior, and, lately, psychology has become one of these. Psychology is a vastly different kind of intellectual framework. Within its system of illumination, many brilliant new facets of man's behavior come to view, facets that never catch the light of biology.

So, which gives the better view of man, biology or psychology? Certainly, both are ways of looking at the very same man. Both are ways of making scientific predictions about his behavior. The answer is simple enough. Each way discloses, in its own particular manner, certain facets of the same human truth. There are occasions when some biological approach leads one to make more accurate predictions about man; others in which a psychological slant opens the way to a better understanding of what man is up to. It is

not that man is himself a hyphenated combination of psychology and biology—a mind glued tightly onto a body—man is simply man; himself neither the property of biology nor of psychology. But he may be looked at through the spectacles of the biologist or through the spectacles of the psychologist, and, may I add, he may be looked at through other spectacles too, through those of theology, for example. As we successively try on new spectacles, each fresh viewpoint opens up to us a magnificent view of humanity.

Now what does this have to do with patients and the psychotherapeutic role of the psychological profession? Certainly this: the patient's discomfort, or the patient's behavior if you prefer, is not itself a biological thing, nor is it a psychological thing. It is the way that we look at it, the way we look at that discomfort, that is biological or psychological. Once we recognize this simple truth about human construction of reality, a lot of things begin to fall into place, including, I think, the proper relationships between the five professions who have contributed to this monograph.

Now let me come back to the quotation from the report which was the starting point of this excursion into epistemology. The statement was, "There is a common notion of a categorical distinction between 'cold' science and the 'warm' human relating that moves psychotherapy forward." The report adds, "Let it be said at once that this distinction is not only false but mischievous." By conceptualizing psychotherapy within the framework of psychology, rather than within the biological framework of medicine, it becomes possible for the psychotherapist to be scientific—and warm—without having to resort to the vagaries of psychiatric intuition.

The psychologist who practices psychotherapy does across his desk essentially the very same thing that he so painstakingly learned to do in performing the research required for his doctoral dissertation. He formulates hypotheses, both deductively from theory and inductively from the seemingly incoherent murmurings of his client. He tests the hypotheses in the interview room and listens attentively to the evidence with that quiet courageous humility that rabidly doctrinaire persons find so hard to accept and therefore brand as sheer naiveté. But this is the scientist now sitting in the therapist's chair, and one may be sure that his techniques will often seem new and strange.

It is said that Carver, the distinguished research chemist and teacher, was wont to say something like this at the beginning of an experiment, "Students, we are about to ask God a little question. This is our particular way of asking it but we must be sure that it is a question we ask and not a reward that we demand, for it will be precisely the question we ask that will be answered, while the reward we demand may never be granted." What better statement of the essentials of experimental design could any scientist ever formulate!

But scientific method is not solely for the man sitting in the psychotherapist's chair. When the client and the psychologist walk into the interview room, they enter together a laboratory of human relations. Both become researchers. Both offer themselves as subjects for the experiment about to be performed. Both observe the client's reactions. Both take careful note of the therapist's responses. And with this new concept of psychotherapy, psychology's break with certain medical—and ecclesiastical—traditions becomes

complete. For, by tradition, the medical man must place his patient in a horizontal position and ask him to assume an attitude of hopeful submission, while the concept of the client as a partner in research construes him in a vertical position. Together, these two persons, client and psychologist, who walk into the psychotherapeutic laboratory, comprise a test tube of human relations and, in each scheduled hour of interview, an experiment is performed by them. Each observes the experimental outcomes. Sometimes the mixture proves unexpectedly explosive. But this has been anticipated. Laboratory precautions have been taken, the test tube is small, and the blast damage is localized to keep it under control.

Sometimes, then, it is man the client, but it is always man the researcher. Perhaps we might well express this new psychological concept of the client role by paraphrasing one of the protestant cries of the Reformation and say, "We conceive that every man has the right to be his own scientist." The client needs only to discover how to ask God little questions. He does not merely collect official interpretations from his psychotherapist. Here is a notion of a client that, to say the least, is not in the medical tradition, and let us not underestimate the upheaval that will ensue from its adoption. Nor should we misjudge the consternation already arising in the ranks of those professional colleagues to whom the concept of "medical responsibility" has become a traditional and cherished rite to be performed upon incompetent patients.

But let us hasten on now with the underscoring of this comprehensive report. Perhaps this is the moment to talk about collaboration with our colleagues in other disciplines. It may serve to soften the harsh criticism unavoidably inferred from what has just been said. Yet I would remind any listener who might have been offended that one cannot speak from great conviction about a vastly new idea without reflecting vivid contrasts upon certain things that have grown old and treasured. May I say, especially to our psychiatric colleagues who may feel at this point that their noses have been tweaked, that there is no occasion for offense. This bold new venture into the therapeutic application of psychology as a science is one in which they might well join us, even though it would mean the open abandonment of those pretenses by which they now retain nominal membership in the medical fraternity. We wish they would stop talking about "medical responsibility," which to us is beginning to sound like "the white man's burden" of British colonialism, and make up their minds to join us in the development of a science upon which psychotherapy can be responsibly based.

We should like to have them on our side. We think they would enjoy doing research. We think they would find the psychologist's framework of scientific thinking deeply satisfactory and something into which they could get their teeth. We think they would find the social outlook of our professional group refreshing and, more, we think their erstwhile medical colleagues would respect them for it.

The report says that psychologists do collaborate with other disciplines. Of course they do! The fact that they do so stems from the very scientific assumptions we have been talking about, and not from timidity, as some would

like to imply. Now we have just made a point of the fact that psychologists believe in collaborating with their clients. Psychologists believe that this is a sensible and humanly decent way of getting on with the psychotherapeutic process. It would be a strange contradiction for psychologists to urge collaboration with their clients while fearing or disbelieving in collaboration with their colleagues.

The report says that collaboration is spelled out in the psychologists' official code of ethics. I might add that I have not seen it so spelled out in any other discipline's code of ethics. Not only that, but I am sure that no other professional group, with perhaps the exception of social work, collaborates half so much in the conduct of their psychotherapeutic and counseling services as do psychologists. Certainly, the proportion of psychiatrists who seek psychological advice when it is urgently needed is still an insignificant minority.

We might perhaps say that psychologists collaborate because they are gregarious, or because they are trained to be articulate, explicit, and open to the testimony of objective evidence. To say so would be correct in part. But the reason goes deeper than this. It lies in the philosophical position that we have already sketched that man is not assigned to the jurisdiction of any particular system of thought, that he is himself neither psychological, nor biological, nor psychobiological. He is simply himself. It is the viewpoint from which he is seen that is intrinsically psychological, biological, economic, and so on. It is this position on the nature of man that makes it possible for the psychologist to collaborate with colleagues with different viewpoints and makes the psychologist cry out against the jurisdictionalism of the medical profession. Here was the underlying premise from which stemmed the action of the Council of the American Psychological Association, quoted by the report, that reads: "Psychology, therefore, does not favor narrowly restrictive legislation, which provides that only psychologists (or teachers, or physicians, *etc.*) may engage in certain applications of psychological knowledge and techniques." The philosophical background of psychologists causes them to believe in collaboration between the professions. In the language of psychodiagnostic concept-formation testing, they attempt to adopt the enlightened abstract outlook on life rather than the concretistic, jurisdictional outlook.

There is much more in this report that might be underscored and documented further, but let me turn from its individual topics to an over-all view of what is going on in psychology these days and where it is likely to lead in the next decade or two.

Let us look at the rise of psychology, not in the competitive context of medicine, of social work, or of religion merely, but rather in the context of society's emerging structure. From the time of the Levites, if not earlier, society has expected certain groups of men to prepare themselves for special kinds of services and to impose upon themselves certain sanctions and controls by which the quality of those services might be sustained at an optimal level. In recent generations, we have called such self-disciplined groups of specialized servants "professions." But professions have also taken it upon themselves to demand a special kind of authority over the affairs of their fellow men. In

a domination-submission form of society, or a leader-follower type of society, if one prefers less vigorous terminology, this assumption of authoritarian prerogatives was tolerated. In the priesthood, the authority was presumed to to have been conferred by God. But during the last century, when medicine emerged as a profession, the authority was conceived in a somewhat different way. It was an authority conferred by virtue of one's training—in the case of medicine, of course, medical training. This authority was encoded in our laws of medical practice. To a considerable extent, it must be said, the clergy also has come to rest its claim to authority upon this new kind of professional foundation. We might mention the rise of other professions too, but the point is probably clear enough as it stands.

But now it is the middle of the 20th century. Society is struggling with some powerful new concepts of social organization and questioning the propriety of having one class of men staring down their fellow men into intellectual submission, and it is asking itself on every hand, "Is this the only way men can build their society so as to make it safe and wholesome? What is authority anyway, and whence does it really stem?"

It is in this climate of inquiry and soul searching that a new profession called "psychology" is arising. Will this new profession be patterned along the lines of the medical profession of nearly a century ago? Or does it have the opportunity, as no profession before it has ever had, to establish itself on a new kind of foundation, a foundation of tested but continuing inquiry? Is it possible to build, for the first time, a profession based upon scientific understanding, with no claim to any kind of superior custody of truth, with no insistence upon privileged control of the persons whom it serves? We psychologists think it is now possible, for the first time, to build a profession upon such grounds. But the challenge is not merely a challenge to psychologists. It is a challenge to all. We psychologists should particularly like to enlist the collaboration of the members of the five groups represented in this monograph. There are some who say it cannot be done. But would it not be a splendid adventure to try?

THE FINDINGS OF THE COMMISSION IN SOCIAL WORK

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Introduction. Social casework is a professional methodology within the field of social work that developed about the turn of the century out of the increasing awareness that human life is extremely complex, and that to help people with their problems in human relationships requires much knowledge of all phases and aspects of daily living. It therefore has attempted what might seem to be a contradiction in terms. It has specialized in the complexity of life and the significance of life's many interrelationships rather than in some part of life or some particular relationship. Social casework has found that real understanding of the individual is possible only through a knowledge of the individual's history and of all the many social and community forces that have impinged upon and continue to influence him. Personal attitudes rooted in previous experience are found to be significant both for the satisfaction of the individual and as a determinant of the number and quality of his relationships to others. It is this wide scope and focus that gives casework its distinctive character and brings it into effective relationships with other professions.

Earliest provisions, in colonial times, for the alleviation of poverty and want and for comfort of the sick were made through the church and civil government. The development of separate institutions or agencies for the giving of social services occurred in this country after the Civil War, when the number of orphans and widows mounted, when an economic depression brought on widespread poverty and want, and when rapidly increasing industrialization and urbanization created for many people new kinds of personal and family problems. Family agencies were developed to relieve distress in families threatened by marital difficulties, illegitimacy, illness, death, or other problems. Child care agencies were formed to deal with problems of orphans and other dependent, neglected, or delinquent children. Social casework basically developed as a professional methodology in the course of giving specific services to families and children, such as relief, house-keeping service, and foster-home finding, placement, and supervision, and increasingly in counseling regarding family relationships. Professional understanding and skill have been developed, and standards of training and practice have evolved largely in this central core of agency experience.

A little later, and increasingly in recent years, social casework has been invited into a variety of host agencies that have brought it into close working relationships with other professions. These professions, in part, have become its interpreters and promoters. Social casework moved into the general hospital to aid in assembling and interpreting social data for use by the patient's physician or in explaining the social significance of handicaps to the patient and his family, and in arranging for prosthetic aids, convalescent care, recreation, and other social services in accordance with a patient's needs and interests.

* This paper, presented by Doctor Woodward at the conference on which this monograph is based, was written by him in collaboration with the other members of the Commission in Social Work.

It moved into the mental hospital and psychiatric outpatient clinic, where it works in direct and responsible relations with psychiatry and clinical psychology in serving the mentally ill and emotionally disturbed. It became statistically the most prominent member of the multidiscipline team in the work of community child guidance clinics, where skill in relationship is a most essential requirement. It has moved into some school systems as an essential part of special guidance services. It has functioned in courts and probations departments, and has become an arm of the churches in giving services to families and children in larger urban parishes and on a broad diocesan or synodical basis. The impact of all this invasion of host agencies has led to further specialization in the particular kind of relationships that are most involved in each host agency. It has also made social casework service available to a clientele that is much more representative of the total population, both as to type of problem and the whole range of cultural and socioeconomic groupings. The increasing use of a graduated scale of fees in family casework agencies and in mental hygiene clinics, and the current growth in the private practice of social casework in some of our larger cities are also extending service to people of diverse educational, vocational, and social position.

The field of social work. All social institutions develop in relation to areas of human need. They represent the organized responses of the community to the needs of its members. Thus social work, largely developed within social agencies, derives its mandate from society, and its ultimate goal is the welfare of society as a whole.

Social work has been defined as: "A professional service rendered to people for the purpose of assisting them as individuals or in groups to attain satisfying relationships and standards of life in accordance with their particular wishes and capacities in harmony with those of the community. Its objectives include not only the provision of material assistance to dependent or needy persons but also the rendering of help to people who have difficulties in making adjustments to their economic and social environments. It is necessarily concerned with the emotional problems of persons, whether these problems are the cause or are the effect of poverty, illness, delinquency, or crime; or whether they appear in marital discord, parent-child difficulties, personal maladjustments of individuals in any economic or social level. It participates in providing and administering those amenities of life, such as recreational and cultural activities, which contribute to an enriched standard of living. It is concerned with efforts to raise standards of living for the entire population, emphasizing in this connection the importance of better housing and improved health, education, recreational, and social services and facilities for all the people. The primary approach of social work is to enable individuals, groups, and communities to meet their own needs and accomplish their own objectives.

"Social work practice can be classified by the principal methods used: social casework, social group work, community organization, social work research and administration."[1]

Social casework. Social casework is a method employed by social workers to help individuals find a solution to problems of social adjustment that they are

unable to handle in a satisfactory way by their own efforts.[2] Its aim is to help individuals and families mobilize both their own personal capacities and the resources in the environment to function more effectively. Stated simply, the goal of casework is to help people achieve maximum self-realization, compatible with the needs of others.[3]

Social casework is carried on almost entirely through two types of agency setting: that in which the casework service is the primary job of the agency, such as the family service agency, child placement agency, public assistance agency, child guidance clinics, *etc.*; and that in which such service is secondary to the main objective, as the social service department of a hospital, school of social work, casework in a court clinic, a mental hygiene clinic, etc.[2]

A recent development that can not yet be evaluated is the engagement of some experienced caseworkers in private practice. The standards for training, supervision, and control set forth herein must, we believe, be provided for and maintained on an equally high level if the private practice of casework is to achieve broad recognition and come into general use. Fortunately, an emphasis on high standards is stressed in the literature on the subject which has appeared thus far.[4]

Casework is prepared to give a professional service to a wide range of people whose productive functioning is either actually or potentially interfered with by physical, social, and psychological forces. The problems brought to the caseworker may take the form of intrafamily tensions, such as difficulties in relationships between husband and wife, between parent and child, or between an aged member of the family and his relatives. They may involve personal relationships outside the family itself, as with friends and acquaintances, or they may center around some area of social functioning such as self-support, household management, the achieving of reasonable educational and vocational objectives, adequate health care, *etc.*[2]

Casework as it has developed in this country rests upon certain fundamental assumptions about human personality and about social values and objectives. It rests first upon belief in the value of the individual, his uniqueness, his capacity to develop and adjust in a way that will bring him satisfaction. It assumes that the purpose of social structures is to enable the individuals of which a society is composed to live as well as possible, rather than the reverse, that man is made for the state. On the whole, caseworkers believe that in the "good society" the welfare of the individual and of society go hand in hand, that what is good for the one is good for the other. They believe that individuals, separately and collectively, have a responsibility for the welfare of each other as well as the right to pursue with vigor their own goals. Contentment, it is assumed, requires both a certain degree of security and opportunity for the expression of creativeness in one of its myriad forms.

Caseworkers operate on the belief (shared in common with other helping professions) that human behavior follows lawful rather than accidental patterns and that, accordingly, it can be understood and purposefully influenced. Human behavior is the product of the unique qualities of the particular individual, his previous life experiences, and the current situation to which he is reacting. In part, he is aware of his own behavior and the reasons for it; in part, he is con-

trolled by influences within himself of which he is not fully aware. He can be helped primarily in three ways: by reductions of the external pressure or limitations by which he is confronted, by acquiring greater understanding of his situation and of himself, and through the direct influence of a relationship designed to enable him to feel the worker's acceptance and positive feeling for him. All casework is a combination and elaboration of these three elements, used consciously and purposefully to enable the individual to improve his social adjustment. Social workers believe strongly in the individual's right to direct his own life, to make his own choices, including the choice of whether or not to use their help. Exceptions to this come when the individual, because of his youth or his physical or mental incapacities, is incapable of directing his own life in a way that will avoid serious harm to himself or others. Typically, children must have some measure of control and guidance. Adults who fall in the "protective" category for one reason or another also may need substantial direction from outside themselves.[2]

Over a long history, social work has developed a considerable experience and skill in administering such services as financial assistance, institutional and foster home placement, *etc.*, to meet the many types of problems for which it has had responsibility. In the course of this history, casework has developed a comprehensive understanding of the social and environmental forces that play upon and influence personal and familial stability. While the personality of an individual influences his ability to make constructive use of these services, the level of emotional development or stability in a great many situations was not the precipitating cause for the problem. Situational and social crises such as depression, unemployment, illness were responsible for the problems and needs of huge numbers of people. Therefore casework had to learn to distinguish between crises situations stemming from environmental causes and crises resulting primarily from inner psychological conflict. In between, of course, there were the large number of people whose emotional adjustment was adequate only during periods when social and environmental forces were relatively untroubled, and whose stability gave way as soon as external pressures began to manifest themselves.

Casework then began to develop skills in differentiating and recognizing the dynamic relationship between inner and outer pressures as causal factors in the particular problems brought to them. In offering a broad range of social services to meet such problems, casework developed not only the social diagnostic understanding that was necessary to evaluate environmental influences on family adjustment, but learned to utilize and modify the environment as part of the over-all plan in helping a family to achieve or regain social and psychological stability.

The casework process was thus compounded out of offering specific services to a variety of persons with a broad range of problems; out of understanding the conflict entailed in seeking and using assistance; and by observing and understanding the significance of the client-caseworker relationship. The casework process also incorporated the skill it derived from learning how to deal with the adaptive forces within the human personality.

The process of evaluation in casework. In responding to such a wide variety

of people and such varying social and psychological problems, casework is developing increasing skill in psychosocial diagnosis.

The term "psychosocial" has been evolved to describe the integration of appropriate insights and knowledge of dynamic psychology with the contributions which stem from casework's own rich experience. This body of psychosocial knowledge is addressed to an understanding of four basic phenomena and their interrelationships; the psychology of the individual (including intellectual and somatic factors); intrafamilial relationships; social functioning; and the social factors operating in the environment and their impact on the psychology of the individual and the family. Particularly in the family agency and, increasingly in other settings, psychosocial diagnosis and evaluation is addressing itself to the family as a whole. It includes in effect a "family diagnosis" concerned with the complex of multiple factors which have contributed to the problem, as well as the quality of current interaction in the immediate interpersonal relations. It is this evaluation of the social and psychological data (including intellectual and somatic factors), their relationship to and impact on one another, that determines the nature of the casework service offered, its goals, and its methodology and techniques. It is this process that initially insures the client the service most appropriate to his need and, as treatment goals and aims arising out of this process are subsequently identified and defined, the client and community have assurance that casework is operating within the bounds of its competence as a profession.

The degree of emotional health or illness within the individual, or the nature of the illness, is not itself the determining factor in judging the suitability of casework as a therapeutic measure. Casework's clients cover a wide range of mental, emotional, and social health. People in reasonably good mental health may have social and interpersonal problems that require the services of a caseworker. At the other end of the scale are people with diagnosed mental illness who are either unable or unready to use psychiatric treatment. These people continue to function in the community, to interact with and influence others. It has been confirmed over the years that many such individuals are able to make some use of casework help in limited areas of these difficulties, usually focused upon specific problems of social adjustment. Problems of this nature are frequently referred by psychiatrists for such supportive help. The family of the mentally ill person often requires the help of the caseworker in adjusting to problems arising out of the presence (or absence) of the sick individual. This help is needed both to insure the health of the family and to create a climate favorable to the ill person's improvement.

These are the extremes in the spectrum of diagnosed problems suitable for treatment by casework. The great majority of clients fall between these extremes. There is a large group of clients with neurotic traits or with symptom neuroses or character disturbances whose emotional disorders or deviations in behavior are expressed through the interpersonal and social problems which bring them to the caseworker.

Since individuals frequently displace their anxiety and are unaware of their basic need, their own original choice of a professional discipline and/or service agency is not always appropriate to their problems. The caseworker takes

responsibility for viewing the client's problems in the full social and psychological context in which they exist and for directing people to the source of help most appropriate to their needs.

Thus the professional services of the caseworker will include, in addition to treatment, consultation and referral to other resources (see section on "Collaboration and Consultation").

Casework treatment. The field of casework at present tends to use such terms as casework treatment, casework therapy, or counseling, rather than psychotherapy, as being more descriptive of the integration of the social and psychological factors for which it assumes responsibility. In addition, this helps to distinguish this service and method from disciplines carrying responsibility for the direct treatment of severe mental and emotional pathology as such.

When the psychosocial diagnostic study and evaluation suggests that casework treatment is the appropriate help needed either on a short-term, intermediary, or long-term basis, one of two* possible methodologies may be selected. In each, the client-worker relationship is the primary facilitating factor in the treatment. Its management will vary.

In the first method, the aim of treatment is to support or maintain the client's current strengths by helping him mobilize capacity and resources to meet his current life situation. By intent, this type of treatment does not aim to increase the client's self-understanding. It leaves the current defenses intact or, when indicated, reinforces them. As a consequence of his experiences during treatment, however, the client may spontaneously acquire a greater degree of self-awareness. His increased integrative capacity, together with the diminution of tension, also reduces the need to utilize destructive defensive behavior.

This type of treatment is appropriate (1) when the client's ego is weak and would be further endangered by self-examination and the accompanying threat to the defense structure; (2) when the client is functioning adequately and is in need only of help in social planning; and (3) when ego-supportive techniques are necessary preliminary to some other form of treatment.[3]

The techniques used in this form of treatment include: mobilization and modification of the environment, reassurance, persuasion, direct advice and guidance, suggestion, logical discussion, and exercise of professional authority—all within the framework of the client-worker relationship.[3]

Persons needing such supportive help may be either (1) those who are handicapped physically or emotionally or are incapable, because of youth or old age, of making suitable plans without help; or (2) those who ordinarily have capacity to manage their affairs but who, at points of severe pressure, are temporarily immobilized. The problems of these individuals usually include those that require social planning and utilization of resources. The caseworker's focus of help is on the specific reality problems that the individual or family is facing and on ways of reducing pressure and relieving undue hardship.[3]

In the second treatment method, the treatment aim is to modify the client's attitude and patterns of behavior by increasing his understanding of himself,

* There is a group within the field of casework who would add a third treatment method aimed at basic personality change in circumscribed areas. The caseworker's treatment effort here always hinges on defining specific impairment in social functioning that can be corrected. The method is not described here further since, in many professional circles, it is still considered "experimental."

of his problems, and of his part in creating them.[3] Its goal is to improve the client's ability to master reality situations as he is helped to gain awareness of his habitual patterns of behavior, including his relationships with other persons and his reactions to specific aspects of his life situation. This treatment, by helping the client to differentiate between subjective and objective factors in life, leads to modifications in his attitudes and behavior. The consequent reduction of anxiety strengthens the client's ability to assess reality, and lessens the use of destructive defenses.

The predominant technique in this type of treatment is clarification. Its aim is to help the client sort out the subjective and objective elements in his situation and to become aware of the subjective elements that distort attitudes and lead to difficulties in social living. Reassurance and educational techniques similar to those used in the first treatment method are also utilized when they are appropriate to the immediate situation and are in harmony with the ultimate goal of the treatment. These may be used when clarification of a certain aspect of behavior seems unnecessary or inappropriate, or when a client is not yet ready for a discussion of certain aspects of his feelings and behavior.[3] With this treatment method, too, help often includes enabling the client to use various other agency or community resources for himself and for other family members.

This type of treatment is appropriate for people who have sufficient ego strength and capacity for positive feeling to engage in this kind of self-examination.[3]

Collaboration and consultation with other professional disciplines. Since social casework is concerned with the social, emotional, and physical aspects of life that are interacting forces in individual and family adjustment, the caseworker always has responsibility for working with members of other professions whose knowledge or services are needed by clients.[5] The caseworker may collaborate (labor with or work concurrently) with other professional disciplines as the latter are needed directly by the client, or consult with another discipline when certain aspects of the other discipline's knowledge are needed by the caseworker to provide the appropriate casework service. When collaboration takes place, it involves a division of labor and a decision as to what aspects or areas of the client's problem will be dealt with, and by whom. Where consultation is used, responsibility for evaluating the problems and treating the client remains with the caseworker.

Both collaboration and consultation most commonly take place with psychiatrists or analysts and other medical doctors, psychologists, home economists, nurses, teachers, and the clergy. They may occur either within the agency structure itself or within the community as a whole.

When either occurs within the agency structure, the persons with whom the caseworker collaborates or consults, and the role of the collaborators and consultants are determined by the primary objective of the setting itself. For example, in agencies whose primary function is social casework, it is social casework that determines the collaborating or consulting disciplines that shall be maintained within its framework, in what measure, and in what role.

When the primary objective of the setting is medical, psychiatric, educational, legal, *etc.*, the question as to whether casework should collaborate or

consult, to what extent, and what its role should be is determined by the professions primarily responsible for the service. In each setting, the main purpose for which the client seeks the institution, the recognized needs of the client, and the primary profession's estimate of the extent to which it can or wishes, within the agency setting, to serve these needs, are determining factors in providing for collaboration and consultation.

The caseworker's concern, in the study and evaluative process, with the total adjustment of the client, whether or not casework treatment is needed or can be used, is perhaps what distinguishes him at present in the broad field of human relations. Ideally and initially, the caseworker is not screening people for his own service, but is looking at their total needs and wondering where they can best be met, irrespective of whether this is apart from or in conjunction with the treatment he can offer. Although all disciplines are used in varying capacities to meet the needs of clients, the psychiatrist is apt to be used most intensively and extensively in social agencies whose primary objective is casework. Psychiatrists may be used as both consultants and collaborators in the following roles: consultants, per se; diagnosticians; therapists; and as participants in staff training and development.

Interesting relationships are constantly developing with closely related healing and helping disciplines: casework and psychiatry are coming closer, with psychiatry showing increasing appreciation of social factors in personal adjustment and casework absorbing greater understanding of psychological factors. At times there is overlapping of function, with work still to be done on the problems that arise out of this. In many quarters, there is the recognition of the inevitableness and value of such overlapping and of the flexibility it can give to team practice. At the same time there is recognition of the areas of distinction between the two disciplines.[3]

In most psychiatric settings, the concept of the clinic team and of team work between the social workers and the doctors is well accepted. The constant mutual exchange of professional knowledge and practice in service to the patient is beneficial both to disciplines and to patients.[6]

In psychiatric hospitals and clinics, there have been four patterns of collaboration, as described by Tessie Berkman in a recent study of the practice of social workers in these settings:[7]

(1) The psychiatrist assumed responsibility for the treatment of the patient, and the worker offered some form of treatment to the relative. This pattern was most common in psychiatric clinics serving children.

(2) The psychiatrist assumed responsibility for treatment of the patient, but the social worker usually offered a concrete service, such as a referral to an agency. This pattern was predominant in clinics within hospitals.

(3) Treatment of patient was provided by the social worker, and treatment of the relative by a nonmedical staff member, usually another social worker. In some instances, the psychologist was designated as the professional person responsible for the treatment of one member of the family and the social worker for the other. The common feature in this pattern was the concurrent treatment of patient and relative by two professional persons, neither one of whom was the psychiatrist, but treatment was "under the supervision of the psychia-

trist." This pattern appeared most frequently in clinics treating children where only part-time psychiatry was found.

(4) Treatment of the patient, usually an adult, by social worker "under the supervision of the psychiatrist" or in consultation with psychiatrists. No relative was involved.

As concepts from social psychiatry are becoming the common knowledge of the several professions engaged in psychotherapy and counseling, there is a trend toward less sharply differentiated roles of each therapist within a traditional clinical team setup, and assignments of cases are made more on the basis of the equipment of a particular worker than of his professional discipline. A study made under auspices of the American Orthopsychiatric Association, New York, N.Y., in 1950, clearly brings out this trend in [8] orthopsychiatric clinics.

Various problems of collaboration and consultation are being worked out in casework agencies and other agencies employing caseworkers. Several of the leading medical schools (for example) are now offering courses (by caseworkers) to their students to emphasize the social factors in illness (and health). Teamwork in medical settings is improving as doctors become more accustomed to thinking in psychosomatic terms.[3] Casework is increasingly considered an essential service in the medical setting.

In educational institutions, there are day-by-day working relationships between caseworkers and guidance counselors. Usually the caseworker, trained for deeper understanding of pathology, undertakes treatment of more disturbed children, thus allowing the guidance counselor to work with the teachers in helping children in the more normal educative process.

In social casework agencies, psychologists are used as collaborators in the diagnostic rather than the treatment process. In host agencies, there may be a different pattern of collaboration.

Much more work needs to be done on the possibilities of collaboration and consultation between the caseworker and minister. The need for a close working relationship between casework and the clergy has been brought out in a booklet on *Community Help on Pastoral Problems*;[9] in an article in the *Journal of Social Casework* (then *The Family*), November 1943, on "Pastoral Counseling and Casework;"[10] and in a published paper on "The Churches and the Non-Sectarian Agencies," December 1954, given at the Institute for Religious and Social Studies, Jewish Theological Seminary of America.[11]

Selection of students. The selection of social work students (casework is one method of social work, the one with which this committee is concerned) for approved graduate schools of social work is based today on an appraisal of the individual's intellectual capacity, academic achievement, motivations for wishing to enter the field, his capacity to form relationships, capacity for growth and change, adaptability, and general outlook on life. Possession of good intellect, a disciplined mind, healthy motivations, ability to grow and change, to form good relationships, to be flexible, and to view life realistically but without deep hostilities are prerequisite qualities to training for work with human beings in trouble.[12]

In addition to securing data from the student applicant's undergraduate school, work, and personal references, most schools of social work require the

applicant to submit an autobiography, and to have one or more personal interviews with a member of the faculty or other representative of the school. In some instances, an interview with the faculty psychiatrist is required. These interviews are geared to an assessment of the potential student's social, physical, and psychological health, and to a determination of his awareness of the demands that professional education and professional practice will make upon him.[13]

All of the data are then carefully reviewed by a faculty committee. The data provide a good basis for identifying the individual who possesses a capacity for social work, and for rejecting or redirecting those who do not. Once admitted to the school, counseling between the student and a faculty advisor who is in possession of all the information available on the student directs the student's initial choice of the particular method of social work in which he will specialize; *i.e.*, casework, community organization, or group work. Further experience will permit the development of even more accurate criteria than we now have for recognizing those combinations of personality attributes that reflect a student's potential for good casework practice.

It is at this point—that of admission to a graduate school of social work and the selection of method of specialization—that the profession of social work takes its first step toward protecting the community by (1) the selection of educable students, and (2) the selection of those pyschologically and emotionally most capable of helping people.

The preadmittance interviews, evaluations, and selection of method of specialization are themselves, however, only a first step. For the student specializing in casework (as with those in other areas of specialty), the evaluatory process continues throughout the student's two year period of study and field practice. (A statement on the social work curriculum follows. See p. 376.) If unanticipated or unusual difficulties in learning arise, the faculty advisor and field work supervior work with the student toward gaining some mastery over the difficulty. In some instances, psychotherapy (outside the school setting) is indicated; in others a shift from casework to some other method of social work is advised. In extreme cases, the student may have to withdraw from the field. In the latter case, the student is helped to make another vocational choice.

Evaluation and training do not stop with graduation from the school of social work. When the educationally qualified worker is employed by a responsible casework agency, the process begun in school is continued through in-service training programs, which include supervision.

Supervision. Supervision is essential in the development of casework as a professional method. It is a method of teaching and of administering social casework. It includes the development of the individual practitioner's skill in practice, the assumption of responsibility for knowing the practice of a group of supervisees and the requirements for further development in practice of the total group.

In this context, practice includes service to the individual or family, management of a total caseload, recording, statistics, responsibility to the community, and any special assignment, in addition to his caseload, given the caseworker.

The relationship between supervisor and worker is usually on an individual basis. They regularly meet alone. There are occasions, however, when a supervisor may work with a group of workers with the same level of experience to supplement individual conferences.

This supervision, especially in the early years of practice, operates in the client's behalf as a protective and fortifying device by means of helping the worker increase his technical competence, and by helping him become aware of and control subjective factors interfering with maximum service to the client. Revelation of too many problems in this area, regardless of severity, that cannot be controlled by educational methods, may suggest that the worker needs psychotherapeutic help to resolve his own conflicts. Caseworkers often seek psychotherapeutic help in the course of their early professional experience because they see the need for fuller resolution of their own inner problems before they can be maximally successful in helping others. It is commonly regarded as good practice for the caseworker to be closely supervised during his first two years as an employed staff member. The supervisor gives considerable guidance in applying theory to practice in each individual case for which the worker is responsible. The worker is given additional theoretical training during this period, and the supervisor helps him to integrate the new knowledge into his practice.

During the third through fifth years of practice, the caseworker continues to be supervised. His increasingly reliable judgment, however, tempers the nature of the supervision. Toward the end of this developmental period, the caseworker may begin, if he is interested in and meets his agency's requirements, the supervision of others under the supervision of a person skilled in teaching caseworkers.

After the sixth year, the supervisory process is much less that of direct teaching and more that of learning through interchange of knowledge and experience. The supervisor continues to have administrative responsibility for all aspects of the supervisee's work, both in quality and quantity. During this period, the caseworker uses supervision to assure consistent accuracy and objectivity in his observations and evaluations of data, and to discuss decisions with respect to choice of treatment methods, techniques, goals, *etc.*, in cases where such consultation is desirable.

Supervision, then, assists the caseworker in integrating theoretical understanding of personality and treatment methods into practice, helps him understand the influence of his own personality and emotional responses to the client to control subjective responses that interfere with maximum service, aids him in developing the highest degree of technical skill in treatment channels, controls the volume of work, and evaluates his total performance.

Thus, the agency, like the school of social work, acts to guarantee the highest quality of professional service.

Other methods of in-service training. Other methods of in-service training for staff development are usually a part of the program of an accredited casework agency. These consist of regularly planned staff meetings in which casework content, agency program, and administrative aspects of work are discussed. In addition, there are usually regular meetings with smaller groups

of staff having similar functions, such as intake workers, supervisors, beginning caseworkers, *etc.*, geared to the development of the staff's competence. In-service training may consist also of seminars conducted through part of each work year by psychiatrists and/or caseworkers, to advance the caseworkers' knowledge of theory needed for diagnosis and treatment, and to enable him to learn new methods and techniques or to improve his use of tested ones. These seminars have different emphases depending upon the needs of any sizeable proportion of staff at any given time and depending upon the needs of a changing or expanding agency program. The application of theory in either diagnosis or treatment, to the individual and/or family with whom the caseworker is working, is a task, however, that continues to lie between him and the supervisor.

The social work curriculum. The Council on Social Work Education, New York, N. Y., sets forth, as current official curriculum policy for graduate professional schools of social work, the following statement, adopted by the council, then known as the American Association of Schools of Social Work, on May 29, 1952.

"The social work curriculum is a cohesive whole, designed to impart a substantial body of professional knowledge and skill, to communicate an undertaking and appreciation of the nature and methods of social work practice, and to insure a beginning competence for the performance of social work functions. It should provide a framework of classroom and field courses and research within which the student may test and use theoretical knowledge, acquire professional skill, achieve a professional self-discipline, and develop a social philosophy rooted in an appreciation of the essential dignity of man. The social work curriculum rests upon the assumption that the student bring to professional education a broad background of general education, including knowledge of fundamental principles in the social and biological sciences. The curriculum as a whole should assist the student to identify with his profession and to accept the responsibilities of the professional social worker. Therefore, the curriculum should stimulate and encourage the student to concern himself with the purposes, ethics, and obligations of the profession; to recognize his responsibility to grow and develop with the profession; to accept appropriate responsibility to work for sound social policy and improved standards of social service in a constructive and ethical way; and to understand and accept the relationship of the social worker to members of other professions involved in the provision of the social services. The individual school of social work is responsible for organizing the recommended subject matter into courses and for determining the appropriate combinations of courses to be required, provided that the curriculum is so constructed as to assure balance of subject matter and progression in learning for all students. The social work curriculum should provide, through classroom and field instruction and through research, knowledge and understanding of the social services, their development, and their relation to the social order, to social change, and to community needs; knowledge and understanding of human behavior, needs, and aspirations; and knowledge and understanding of social work practice. The program should provide for acquisition, in the first year, of beginning knowledge and skill in these areas, with

the second year extending knowledge and developing skill, as appropriate to the students' professional interest within these areas.

"The Social Services: Knowledge and understanding of the social services should be acquired through study of current social welfare programs under public and private auspices, together with their historical development and progress towards meeting the needs of people. Such an approach implies study of the social services as they are affected by social, political, and economic influences; evaluation of the social services in relation to the social and individual needs which they are designed to meet; appreciation of the contributions of its leaders; and an appraisal of the role of the social work profession in the formulation and execution of progressive social policy. Attention should be given to the range, variety, and inter-relationships of social welfare programs, and to their actual implementation in the light of accepted standards.

"Human Growth and Behavior: Knowledge and understanding of human behavior should be acquired as an indispensable base for social work education and for all social work activity. Normal physical, mental, and emotional growth should be considered with due regard to social, cultural, and spirtiual influences upon the development of the individual. This requires study of the individual from the primary patterning of early family relationship through the subsequent periods of his life. Study of the interaction between the individual and his environment should accompany consideration of each stage of development. Attention should also be given to deviations from the normal as manifested in social and emotional difficulties, and in physical, emotional, mental disability or disease. The curriculum should provide for all students, basic knowledge and understanding of group behavior and group relationships as they affect or are affected by the personalities, needs, and interests of the group members.

"Social Work Practice: Knowledge and understanding of the practice of social work should be acquired through a planned sequence of courses designed to stimulate and encourage a scientific attitude of mind and a disciplined approach to social problems and human relationships. This requires related class and field instruction that provides continuity in learning and progression from the simple to the more complex. Such progression has its best beginning in person-to-person and person-to-person group practice in which the interplay of social influences and psychological forces in human life may be observed with greatest clarity. In this practice, the student learns to use himself as a professional person and to apply his increasing knowledge in a manageable unit of experience. Class and field instructors share responsibility for assisting the student to make progressively greater use of his knowledge of individual and group behavior, of social organization and of his developing skill in social work practice. Basic preparation for social work practice requires field courses with planned content and of sufficient duration in a given agency to offer the student actual experience as a responsible agency representative in helping individuals or groups. Opportunities for field experience in working with community groups, in administration, and in research may be provided for students with basic preparation and demonstrated competence in working with individuals or groups. Provision should be made for all students to receive an introduction

to the common objectives, principles, and methods, as well as to the unique elements, of social casework, social group work, community organization in social work, administration in social work, research in social work. Class and field instructors should be prepared to identify the professional skills that are common to all social work practice and to assist the student to develop an awareness of how these common skills are utilized in all social work practice."

Research in casework. There are many research programs under a variety of auspices in social work, but this report is limited to research programs in social casework.[14] Casework has consistently used the supervisory conference, the staff seminar, and the professional workshop to "examine its own work and advance its professional competence." The theory and practice of casework today is based primarily on clinical analysis of case records, direct experience with clients, and adaptations of theory and knowledge from dynamic psychiatry or, to a lesser extent, the social sciences.

While the clinical analysis of records and the critical scrutiny of one's experiences, theories, and techniques by one's own colleagues is of inestimable value in advancing professional practice and competence, it has seldom been done in such a way as to meet the requirements of systematic research. Within the past seven or eight years, however, there has been a remarkable development of interest in research among caseworkers and administrators of casework programs, plus a willingness on the part of a few large agencies and foundations to invest money in the scientific examination of casework practice and its results. The most rapid strides have been made in centers utilizing a multidiscipline team of social scientists and practitioners.

It is in those agencies where research departments or divisions with permanent, full-time research staffs have been created that casework research can be expected to come of age. These are few in number and will probably always remain so in so far as social agencies are concerned. One can hope, fowever, for greater development of research centers in the universities having graduate schools of social work. At present, to our knowledge, only one such center exists, and its development is very recent.

The most extensive program of research in casework has been that conducted by the Institute of Welfare Research of the Community Service Society in New York, N. Y. There a staff of experimental and clinical psychologists and caseworkers and, recently, a sociologist have been engaged in a program designed to develop and test tools for measuring the effectiveness of social casework. This staff has created one measuring instrument—the Movement Scale—which has proved to be highly reliable and has been applied by workers in a variety of settings as a measure of the change occurring in a client and/or his situation while receiving casework or counseling. The institute has also conducted follow-up studies of both brief and long-term cases, and has experimented with electrical recording of casework interviews for research purposes.

The Jewish Family Service of New York has also had a permanent research department for several years that has engaged primarily in casework research. This group's study of brief service cases was the first extensive one of this very important group of clients. The social scientists in this program have been anthropologists and sociologists.

In Philadelphia, the Marriage Council, which is a casework agency, has conducted, with the help of mental health funds provided by the United States Public Health Service, a series of studies on the reliability and validity of the case record. Currently, they are engaged in a follow-up of persons they have counseled in recent years. There the research staff have been psychologists who have worked very closely with the casework and psychiatric staff in developing the schedules and questionnaires used.

At the University of Chicago, a Research Center has been established with the aid of a grant from the Field Foundation within the School of Social Service Administration. The center's primary emphasis is to be on casework research, and its first project, carried on in conjunction with the Family Service Division of the United Charities and the Jewish Family Service of Chicago, is an exploration of the effect of client motivation, capacity, and opportunity on the results of casework. The director of this program is a caseworker with an unusual background of research training and experience. Available to her for consultation are the faculties of the school of social work and of the social science departments of the university.

Other developments in social work in recent years that bode well for research are the formation of a professional organization of workers engaged in research in the field and the rapid increase in schools offering a doctoral program with strong emphasis on research.

Although research in casework, to paraphrase a familiar statement, is in its infancy, it is a healthy, vigorous infant with an excellent chance of achieving maturity before too many years have passed.

Society's expectations and sanctions. As Gordon Hamilton has stated, "Social work lies midway between the healing and educational professions, and draws on the insights of both. It offers both social treatment and psychological education, depending on human needs."[15] In its credo, social work shares much with these professions—that individual persons have great worth; that each individual has the right to self-determination to the full limit of his capacities and regard for the well-being of others; and that people have marked capacity for adjustment. Social casework has especially served those who have acute problems, and has developed special skill in doing this. Increasingly, society counts on the profession for basic casework services to families and individuals in need of understanding and help, thus according the profession the same kind of sanction it gives to other helping professions. Through the years, the prestige of social casework has suffered somewhat from its initial and continued association with generally stigmatized problems that have been less universal and less inevitable than problems of illness. Consequently, social casework (unlike medicine, pastoral service, and education, which are used by people of all social levels) has until recently been limited considerably, in the minds of the public if not in actuality, to less privileged groups. As noted earlier, this is changing as service is given more and more to people of diverse economic, educational, and social background.

The origin of social casework in complex problems of social relationships and its continued association with difficult social problems have usually given the profession a sense of humility and dedication to its varied and difficult tasks.

At times it has experienced frustration and shown some tendency to escape. Sometimes it has escaped into undue preoccupation with its own processes and a defensive need to overexplain itself to all who would listen or read. For many years, it somewhat overidentified with the underprivileged groups it served and was resistant to policy changes that would have made it available to more diverse groups, including the financially well-to-do who nevertheless need its professional skills in connection with family or other psychosocial problems. In the process of learning what psychiatry had to offer for the understanding of psychodynamics, some practitioners tended to overstress psychological factors to the relative neglect of social casework's own focus on interpersonal relationships that potently influence people's behavior. Fortunately, these tendencies have dissipated as the profession has matured.

Social casework has ceased to be society's accident ward. It is joining hands with the social sciences and the other specialties in the field of social work to get at the roots of social pathology and to organize community forces to prevent, as far as possible, the development of the more serious individual and social problems. It has taken its place with medicine and public health and with education, law, and religion as one of the positive institutions for building and maintaining a healthy society. Its continuing tasks are to remove or reduce stresses and conflicts caused by unfavorable environments, and to help people find and use the potentially constructive forces in themselves and their situations so that they can pursue their goals effectively and obtain genuine satisfactions.[16]

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THE PLACE OF SOCIAL CASEWORK IN PSYCHOTHERAPEUTIC TREATMENT METHODS

(Discussion of the Findings of the Social Work Commission)

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The commission is to be congratulated for the production of a report that describes so adequately the profession of social work and, particularly, the field of social casework. In relation to certain basic questions posed for this conference, the report seems to make the following answers:

(1) Casework is developing therapeutic methods of a psychosocial nature for treating problems of social malfunctioning caused by, or complicated by, personality disorders and mental illness, along with problems caused by other factors.

(2) The psychosocial therapy provided as a professional service is rooted in social work process and objective. It is characterized by techniques influenced by psychoanalysis that are held in common with other professions but are differentiated from the specialized psychiatric medical techniques and, in the main, from the specialized uncovering techniques of psychoanalysis.

(3) The training for casework psychosocial therapy is an intrinsic part of the professional education of the caseworker and is not an extra training for what is sometimes called a higher form of "therapy."

The important question, that for various kinds of emotional and social problems there are preferred kinds of therapy or counseling to be provided in appropriate settings by qualified persons, remains to be spelled out in clearer detail through more extensive case study and through research directed toward this end. I should like to discuss further, however, the subject of selection of cases for casework treatment on the basis of current practice at the risk of oversimplification.[1]

The main lines for casework selection in the areas of personality disturbances indicated in the report are for problems expressed through family relationships and other interpersonal relationships, as well as in problematical social behavior, and problems centered in situational difficulties. These are the problems that clients bring to family and children's agencies and mental health clinics, as well as to medical and psychiatric social service departments. The earliest concerns and method developments in casework were with helping clients with socioadjustment problems through environmental support techniques and psychological support. As indicated in the report, other techniques have been those of clarification and, I should add, selected interpretive techniques and the use of transference by worker-client relationships. These techniques are used precisely, based on knowledge from psychiatry and, particularly, from psychoanalysis, which has delineated a theory of ego psychology and has clarified the nature of the dynamics of personality functioning. Psychoanalysis has contributed new knowledge, particularly about the neuroses and character disorders, and also about the psychoses.

Casework treatment methods of clients who fall in various categories are differentiated on the basis of the specific clinical diagnosis and its interlocking with a particular social configuration. The way in which the illness or emotional disorder influences the client's characteristic relationship patterns, reality sense and judgment, self-worth, and ability to assume various adult roles and obligations must be determined. When the problem in social functioning is caused by the personality disorder, or when the social situation reactivates a personality disturbance, the caseworker utilizes psychiatric consultation or psychiatric examination for the definitive diagnosis and delineation of the psychodynamics. The clinical diagnosis is meaningful because it indicates the degree of pathology, the reversible or irreversible manifestations, the longitudinal view of the illness and the prognosis. This psychiatric appraisal, together with the social history and facts about the social functioning, along with such other specialized diagnoses, *i.e.* medical or psychological, as may be indicated, make up the psychosocial diagnosis. This, in turn, enables the caseworker to determine the suitability of casework as the method of choice. Knowledge about the modifiable features, the strength of the ego, and the conditions under which the disorder may subside or become quiescent, will be used by the caseworker to construct a meaningful worker-client relation, to select the areas for environmental and psychological support techniques, and to indicate whether clarification and selected interpretative techniques are appropriate. What I am saying here underlies an approach that is in sharp contrast to any definition of a therapeutic method expressed in loose generalizations, which denies that explicit knowledge of pathology, clinical and social, is central to the treatment of personal and social adjustment problems. Important also is the fact that the social study may contribute basic facts about environmental family and relationship determinants that aid in the formulation of the clinical diagnosis, as well as facts about the external conditions and relationships that promoted functioning and those that contributed to breakdown. This knowledge is primary knowledge in social casework, and it is a specific contribution of social casework to the other helping professions.

To return to the selection of cases for social casework, it has long been known that the treatment of personality disorder can be undertaken from within or from without, or by a combination of both approaches.[2]

Otto Fenichel writes "there are many ways to treat neuroses, but there is only one way to understand them . . . There are many reasons why a nonanalytic treatment might be preferable to an analytic one."[3] He points up the need for systematizing a nonanalytic psychotherapy. He goes further to say "a psychotherapy based on psychoanalytic knowledge can design a method of treatment which includes combinations of limited interpretations, provocations of certain kinds of transference, providing well chosen substitute outlets, alterations of the environment, suggestions for, or prohibitions of, unconsciously tempting or reassuring situations or activities, the verbalizing of actual conflicts and advice about mental hygiene."[3] This formulation describes the central task of the casework method of psychosocial therapy, which is well under way.

A review of social work literature and case study shows the outline of established casework treatment method in the following kinds of cases.

There are those cases in which the event in the present situation is repetitious of an earlier trauma and reactivates the intrapsychic conflict. Because of this, the anxiety is acute and the defenses are strained. The discomfort is great, repressions are loosened, and suppressions give way, so that the client needs and may be accessible to treatment at this time. It is known that an external situation, while it does not create neurosis, may be a precipitating factor in its development. The external situation causes frustration, poses danger and temptations that arouse anxiety, and is met, in turn, by regression and other defensive measures. Diagnostically, this group of cases fall in a variety of clinical classifications, particularly the severe neuroses, acute anxiety states, flare-ups, and recurrences of somatic illness.

The techniques include (1) the construction of a relationship which fits the needs of the client in transference terms, and with positive features in the reality aspects; (2) reassurance that he can be helped to meet the current problem, supported by encouragement, proper intervention in environmental difficulties, and wise counseling; (3) using the verbalization of earlier childhood memories and feelings, now in the foreground of preoccupation, for emotional release and to lay the groundwork for self-understanding; (4) clarification and selected interpretations that aid the client to separate the present reality from the threatening childhood situation, and to gear his behavior more appropriately; and (5) opening new opportunities for sublimations or constructive expressions of neurotic needs.

Cases of mild neuroses and residual neurotic problems affecting maturation, which show up in disturbances in marriage, in parenthood, and in other adult roles and social requirements, also lend themseles to this approach.

Similarly, phobic clients who have worked out a balance in social adjustment by setting up protections for themselves in work and living situations, may be thrown off, if these external situations are disturbed. Treatment involves the restoration of protections in the environment, and sometimes encouragement for growth beyond the fears, in the corrective relationship, and in the opening of new ventures.

Compulsive clients, ridden with demanding superego structure, and subject to depressive trends and expressions of unconscious hostility that make them unable to work effectively, or be good marital partners, or parents, may be helped by a corrective relationship, emotional release, rechanneling of their need to control, the setting of difficult tasks in reality more constructively focused than earlier self-punishing activities, and some development of self-awareness.[4]

Within the group of cases coming to caseworkers, certain criteria have emerged for referrals for psychiatric treatment. To a large extent, the development of criteria has been at a standstill on the operational level because of the lack of psychiatric treatment by psychiatrists available in the community on either a private or mental health clinic basis. It is clear, however, that categories of illness or kinds of symptoms provide no ready formula for the division of labor. The qualities of ego strength and ability to make use of

the specialized introspective techniques of psychoanalytic therapy at the one end of the scale, and the severity of illness which marks the need for medical psychiatric treatment are two points of departure. It may be essential, even in these cases, for an initial period of treatment by the treating profession selected by the client before the refinement of diagnosis and capacity to benefit by one method or another can be established. Some cases may well be treated by either profession. Some may not benefit from either.

Casework treatment methods for clients who fall in the clinical categories of character disorders, borderline problems, and ambulatory schizophrenia are also being formulated in both mental health clinics and social agencies.[5] A clinical understanding of these illnesses, and a knowledge that illnesses express themselves not only in intropsychic ways but in forms of social maladjustment and disturbance in interpersonal relationships, suggests that a large part of any social agency clientele falls in these classifications. Therefore any formulation that these cases shall be treated only in mental health clinics, and by psychiatrists, is unrealistic. Many of them are not accessible to psychiatric treatment, particularly the methods using uncovering techniques. They are in need of social treatment, and some can benefit by supportive psychosocial therapy, which is included in the casework method. In the cases of character disorders, current efforts are studying the way in which the preoedipal character structure, centering a need to be looked after, forms the basis for a dependent transference which may be used to stimulate growth and improved social functioning.

New thinking is also emerging about the responsibility of social agencies and mental health clinics for casework with the discharged psychotic patients, which again would involve the proper psychiatric collaboration.

In conclusion, it is fair to say that casework is treating and must continue to treat certain personal and social adjustments problems caused by psychic disturbances, along with other kinds. The social work profession must take responsibility for defining its distinctive knowledge, methods, and techniques. It must identify the knowledge and techniques held in common with other professions. It must enter into true collaboration with other professions based upon differential treatment considerations. Each profession must submit to scrutiny of its methods and techniques, rather than defend them categorically or deny the import of its endeavors. Professional ethics demand a strict accounting of the treatment of human suffering.

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SOCIAL CASEWORK COUNSELING

(Discussion of the Findings of the Social Work Commission)

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The straightforward and lucid affirmative statement of the Commission of Social Work offers a discussant many avenues for further elaboration. But I shall attempt to hew to one question only, and that is this: what is there about social casework counseling that is different from other professional counseling, and by what signs or qualities may social casework be identified and characterized? This is an important question, it seems to me, affecting both the internal security of social caseworkers and the external interpretation of ourselves in order that laymen and other professions with whom we work should understand and use us appropriately.

Social casework may be said to be to social work what psychoanalysis is to psychiatric medicine—one process in a body of professional knowledge, commitment, and operation. As such, it is based in the profession's philosophy, which holds that the welfare of individual man is both the end and the means to a good society. But this is not unique with us; it is, stated in other terms, the philosophic base of all human welfare professions. Social casework incorporates, uses, and builds into a body of knowledge about the dynamics of human behavior. But neither is this unique, for all professions engaged in psychotherapeutic endeavors subscribe to the major tenets of psychodynamic theory, with minor differences and emphases. Social casework has developed a methodology in which the potent forces of relationship, emotional release and support, corrective and educational means are utilized. But these are likewise the vital helping means to other forms of counseling. And many other likenesses may be found to exist. In seeking to find the particular identity of social casework, I add nothing new to the commission's report. I simply lift out of it three major factors that, it seems to me, are to be found in social casework in such consistent configuration as to make them the characteristic conditions of this counseling practice. They are:

(1) Social casework carries the social responsibilities and value system which society has vested in the social work profession.

(2) Social casework's therapeutic endeavors maintain a particular social focus and, out of this, there has developed some special knowledge of man in his encounters with social relationships, problems, forces, and of the social instruments fashioned to meet his needs.

(3) Social casework is an institutionalized practice.

If social work were to adopt a symbol for its profession, as medicine has adopted the caduceus, for instance, it might well use the head of Janus. Janus is the god, you remember, whose head has two faces, each of which looks in the opposite direction, but both are joined together. As a symbol of social work, he would be looking with one set of eyes upon individual man, with the

other upon the society in which man lives and, in the light of his joined perceptions, he would ponder upon their interlocking relationships.

Among the counseling professions, social casework has carried a particular commitment to this dual concern and concept: that man can develop his powers only as his society provides the wherewithal and that, conversely, a society can maintain its soundness only as its individual members are sound; that the welfare of the individual and the welfare of society are indivisable. Social casework, then, is the expression of the concern that help be given person-by-person or family-by-family in order that they may resume or achieve socially useful and satisfying lives.

Brought into being by society's superego, the profession of social work has consistently maintained recognition of its heritage. Indeed, this may in part explain why social work is not more loved—the conscience is often regarded by all of us as something of a nuisance.* From among the ranks of social workers have come the constant drives and insistent pushes for such changes in societal structures and provisions as will permit individuals to achieve some sense of their own worth, and some feeling of fulfillment. Historically, we are a reforming profession. (I use the word "reform" in full recognition of the derision it has come to evoke. It is food for some thought that, in our present day society, "do-gooder" is a contemptuous appellation. Only when reform is motivated by blind drives to wield power over others and as it takes no account of the rights of others does it merit our censure. Otherwise, to reform, whether aspects of a society or of a personality is really the aim of every educational and therapeutic endeavor.) We are a reforming profession even today, although many of us, immersed within complex agencies in intricate urban centers, tend to lose sight of this. Throughout the country, social workers remain involved with legislation for social change, taking sometimes a small, sometimes a large part in planning, administering, and reforming societal instruments that affect the physical, social, and psychological welfare of literally millions of people.

But what, you ask, does this have to do with psychotherapy and counseling? I believe that even were we to rule out of our thinking the almost 6,000,000 men, women, and children who, as recipients of various forms of public assistances, receive economic, social, and sometimes psychological aid from social caseworkers; even were we to rule out the thousands more who, as clients of privately supported agencies, receive material services along with psychological help from social caseworkers; even if we were to limit ourselves to that small segment of casework that is exclusively concerned with "pure" counseling; even there we should find that social responsibility, social concerns, and standards are notably present.

First, the agency in which the social caseworker operates is itself a social institution, whether it is explicitly a social agency or a hospital, a clinic,

* For a most thoughtful discussion of this point and others in this section, see Charlotte Towle's "The Distinctive Attribute of Education for Social Work," *Social Work Journal*, April 1952, vol. XXXIII, No. 2. See also her "Social Casework in Modern Society," *Social Service Review*, June 1946, vol. XX, No. 2; and "The Social Components in Social Casework," Helen Harris Perlman, *Proceedings of the National Conference of Social Work*, 1953.

a school. Within its walls, a certain social environment exists, certain physical and operational arrangements hold that influence, badly or benignly, the effectiveness of the counseling help given the client or patient. Whatever other disciplines are gathered together in such settings, it is, I believe, the social caseworker who carries a special responsibility to view with an appraising eye the means and modes of agency operation in their impact upon the client or patient, and then to bend his efforts to promote such changes, or reforms, if you will, of agency policies and structures as will better convey its beneficent intents.

Of course, this is the narrowest focus of the caseworker's social concerns. Out from this single unit, the client's social environment widens to family, neighborhood, work, school, and community at large. True, no social caseworker can give himself in equal parts to concentration upon individual counseling and upon social action. Neither can he claim membership in the social work profession, however, if he does not transmit to other responsible persons his concern and support for such social change or provisions as may be exemplified in his individual client's needs.

Another aspect of the social responsibility that permeates social casework is the implicit charge upon the caseworker that his client be brought, certainly in the ways he behaves, hopefully in the ways he feels, into harmony with the requirements and standards of society. It is to this end that a community supports social casework. The implication, then, is that the social caseworker cannot be "neutral" as to the nature and outcome of his client's behavior. He is a carrier of society's values and standards, both of its requirements and its permissions. That there are puzzling problems in such a role and function is obvious in a mobile society such as ours, in which standards and mores are in rapid flux. Within our brief lifetimes, startling changes have taken place—certain sexual behaviors have been accepted, for example, that would have been unthinkable a generation ago, and certain business behaviors rejected that were scarcely questioned before. Moreover, we know that it is certain rebellious, unconventional souls (endowed with other attributes, too, one must add) who break new ground for progress in our values and standards. Nevertheless, at any given time, certain broad general agreements hold in a society about what is considered to be good and desirable, or bad and undesirable, for individual and community life. A marital partner is supposed to carry certain rights and responsibilities; a parent has certain legal and moral privileges and obligations; an employee and a student have obligations to meet certain requirements, and so on. And the caseworker, in turn, is supposed to "stand for" his society's good and desirable ends. Thus, for instance, he is concerned that family life provide a good climate for children's development and, when his client is a parent, his aim must be not simply to help the man or woman feel better as an individual but to help him operate better as a parent. Or, if it becomes clear that the latter aim is impossible of achievement, to consider whether or not the children can weather the harm being done them. Whatever the nature of his client's delinquencies, the social caseworker must convey, combined with his acceptance of the person, his

firm rejection of the behavior, must keep one eye and perhaps one hand in the social situation upon which this person preys. Incidentally, I think we have insufficiently developed our appreciation of the therapeutic values inherent in the caseworker's being a representative of society. That society can accept and be helpful at the same time that it expects and guides towards that expectation, and that love and requirement may be combined in one relationship is, in itself, a new experience for many people.

There is yet another societal charge that social caseworkers carry, and that is to counsel and influence persons who themselves do not seek or even want to be helped. For a time, it was a cliché among social caseworkers that "you cannot help a person who does not want to be helped" and, in some social agencies, eligibility for service still hinges upon the client's mobilized will for change in himself. Yet the fact remains that there are parents who neglect their children, adolescents who run amok, schizoid personalities who drift without anchor—all manner of persons who need but do not seek aid for themselves. These persons seem, to the supporting community, to be the proper charges upon caseworkers; indeed, if they are not, what professional group or what organized resource is provided for them? Nor is it only the indignant or uncomfortable layman who sends such persons to the caseworker. Even other professions—psychiatry, medicine, teaching, to name only a few—not infrequently turn over to the caseworker such persons as they have, in effect, washed their hands of, because the persons lack sufficient motivation or capacity to be responsive to treatment efforts. Is there any validity in such referrals? Two things are true: first, that social work is charged by society with helping the helpless or, failing this, with protecting the victims of such persons against the consequences of their socially unacceptable behavior; and, second, that casework in its therapeutic efforts has some different means by which to try to deal with such persons and some different goals. (Recently there has been a considerable flare of interest in casework circles in the problem of the pursuit and engagement of unmotivated, unwilling persons who, by the community's standards, need social and psychological rehabilitation.)

The goal of social casework with any individual may be said to be not personality change and reorganization, not release from discomfort or tensions (although either or both may occur), but the enabling of a person to use his great or small capacities to cope with some problem in his current social living. It sets no *summum bonum* for the individual except that, within his own limits or powers, he strive to overcome the obstacles that block his effective living or to move toward some socially desirable goal that is his. To this individualized end, casework counseling brings some particular emphases, knowledges, and resources.

Typically, the caseworker's focus is upon the individual in his social functioning. His work with emotional disturbances is upon those anxieties created or roused by the current reality situation. He is aware of and, indeed, should establish the facts of his client's social reality and its significance to the problem he brings. Typically, the caseworker deals with persons who are more well than sick, more master than victim of themselves; but when he does deal

with the sick—as with the neurotic character disorder or the schizoid personality—he works not on the illness but on enabling the person who has the illness to function in some approximation of social adequacy.

Out of the maintenance of this focus through many years, phases, and practices have come certain special knowledges. It is empirical knowledge, as yet unsystematized and insufficiently conceptualized, and, perhaps because of this, it has tended to be overlooked and undervalued by caseworkers themselves. Parenthetically, I must say that, except as we identify and conceptualize that knowledge, we shall continue to feel dependent upon the knowledges of other professions and to relegate ourselves to being "appliers" of what others have thought. Here I can only suggest, not discuss, the content of that knowledge.

I suppose none of the counseling professions knows more than casework does about the psychological meanings of money. To need money and have none, to get money "for nothing," or as a "right," to ask for it, to feel demeaned or gratified at getting it—all the interlaced nuances of economic and emotional dependencies, these are long known to caseworkers. The many other social means by which the individual's psychological adequacy is sustained or broken down are well known in our profession, how social assaults, whether within the intimate unit of family or the impersonal unit of community, can undermine personality growth and adaptations and, conversely, how the presence of social sustenance and resource may serve to cushion the unstable personality and promote growth in the sturdy. Obviously, this kind of knowledge is commonly grasped. The difference is that casework utilizes it in practice, first, by ascertaining the facts of its client's social reality by gauging their psychological import, and then by marshalling social resources by which it may, if necessary, be modified in the interests of the client's social and psychological welfare.

Another particular area of casework's scrutiny and operation is upon the client not as an isolate but as a person in constant interacting relationships with other persons. We believe that the nature of an individual's personal maladaptation can never adequately be established, evaluated, or modified unless the potent persons in his current life situation are taken into account. Their play upon him and the particular quality of their stimulating and responsive behavior, the balance of rewards and stresses in interrelationship must be known and assayed in order to estimate the individual client's neurotic or realistic behavior. Often such influencing persons may need to be drawn into the therapeutic or counseling orbit. It is one of casework's special skills that persons vital to the client's growth and adjustment are treated, not as tools to be manipulated or set in static relationship but as persons who have needs and want gratifications of their own and who must be helped to achieve some of these if they are to act upon the client in benign rather than malign ways.

Related to this is casework's knowing and using the social resources and opportunities of the community in the client's interest, of appraising their positive or questionable value, and of making good connections between them

and persons who need them. For example, a caseworker knows—or ought to know—more exactly than do members of other professions what the possibilities and limits are in foster home placement for a certain child, what the reality of a children's institution is, what hazards lie in a client's applying to another social agency, and so one. In his work with other professions, the caseworker should be able to interpret and advise on the possibilities or limitations of existing social resources. This is not to say that he is always a walking directory. It is rather to say that he knows what kinds of resources exist; what, in general, they have to offer in relation to particular problems; and how to make the most productive liaison between them and the client.

The third differentiating characteristic of social casework practice is that, typically, it is an institutionalized practice. It is practiced under the aegis of of an organized agency representing some aspect of social purpose. In the social agency, which is primarily concerned with family and child welfare programs, the caseworker carries out the agency's major purpose. In other human welfare agencies—medical, educational, correctional—the caseworker carries out one part of the agency's intent, properly that part that gives cognizance to the psychosocial factors in the client's good use of the agency's service. This means that the social caseworker's practice is shaped and colored by the agency or setting he represents. He is both limited and empowered thereby. His treatment goal, what he will do, and the modes and conditions of his operations are to a considerable extent predetermined by the program, policies, procedures, resources, and authorizations of his agency. Of course, a number of other professions are likewise institutionalized. The teacher, unless he is a private tutor, is an agent of a school system; the minister represents his church, or, if he does not, he must build a new church organization about his deviation; and even the doctor of medicine and psychiatry (so often envied by the social worker for his freedoms) is increasingly concerned to be identified as a member of a hospital staff, a clinical group, a representative of some "school" or organization of thought and knowledge. Yet, within the several counseling professions, the caseworker in social work is probably the least free-lance, the most bounded by the functions and structures of the social agency that hires him to carry out its purposes.

This is not without its problems, many of which are in the ferment of discussion within our profession. There are agency situations where out-moded structures strangulate creativity; others where restricting policies cramp the helping intents; others where administrative failure to identify professional responsibilities make of the caseworker the jack-of-all-work and master of none; still others where frozen hierarchies of function keep the practitioner in the position of least status, salary and otherwise. Moreover, it is argued by some that the knowledge and skills of casework ought to be proffered to persons who, because of the conception that social agencies are for the poor, will not use our profession's services except as they emerge from their social welfare auspices.

Of course, there is no valid case to be made for inutile structures, paradoxical policies, or ossified or spongy administrative practices in social agencies.

While there may be reasons for their existence, there are no arguments to support them, and they call for the discussion and action, mentioned before, that social workers themselves must initiate. But there are, I believe, arguments to support the advantages and desirabilities of the social agency auspice for social casework practice. These arguments are in the interests of the caseworker himself, of the profession, and of the persons who need and use casework help.

For the person seeking help, the social agency banks a fund of resources. It represents an organization of means—money, channels to material and psychological arrangements, and professional experience and expertness. Many of these are so costly and complex as to be unavailable except through organized auspices. It is of obvious advantage to the client that the caseworker can make available to him not only his relationship and skill but, when necessary, can draw upon and offer the agency's material and experiential resources.

For the caseworker himself, the social agency of good standing provides, for some time after his formal professional education has been completed, a continuing teaching-learning opportunity. Supervision as an educational process, which assures effective service to clients, has had its highest development in the social agency. As the tutorial relationship moves, with the caseworker's growth, into becoming a more consultative relationship, the interchange of thinking and experience feeds into the agency's store of knowledge and thence into that of the whole profession. Add to this the fact that almost all social agencies provide other opportunities to its staff members—in-service courses, money to attend institutes or conferences, and so on—and the role of the agency as nurturer of the caseworker's professional development may clearly be seen. Actually, until social work achieves licensing, it is the social agency that stands as the chief bulwark and promoter of casework's professional standards and status. The social agency stands, in short, not only as society's organized will to assist persons in social need, but also as our profession's auspice and proving ground.

Perhaps the sharpest test of this configuration of difference that I have proposed is available in the consideration of the social caseworker who goes into private practice. Such a worker is often a caseworker of high professional competence and of considerable experience. His professional ethics and his helping intent stand inviolate. But is he a social caseworker? (This is not, let us recognize, the same as asking is he being good or bad!) To my knowledge, this title is never used by him as his professional designation. It may have too little meaning for his prospective clients—or too much. But it is certain that he no longer is committed to the over-all concerns of social work, nor does he necessarily carry the sanctions or represent the standards or will of the organized community through an agency. He may retain a social focus in his counseling but, as "there are not enough psychiatrists to go round," he may be drawn more and more into dealing with the sickness of his client-patient. When he goes for consultation, it is not to social caseworkers but to psychiatrists that he goes, and it has long been known that one identifies with

the source of one's vital learning. And, finally, as a private practitioner without an institutional connection, he can make no formalized contribution to the development of social casework.

I present these ideas of social casework's special characteristics as food for further consideration, along with the commission's report. The fact that, in many ways, we are like other counseling professions is an important fact; it makes it possible for us to communicate and cooperate in common purpose. But the need to know our special difference is important, too, so that in collaborative practice we can build into and enrich one another's services rather than proliferate dilutions of them, and so that in single discipline practice we can name and claim our professional identity.

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Remarks

Emmy Aufricht: I should like to raise a question that combines the two discussions we have had on the issue of private practice. I happen to be a caseworker who is more and more moving into private practice, with additional postgraduate training, as it were. As mentioned by the psychological report, the report of the Psychological Commission spent considerable time on that profession's standards for its own members as the latter go into private practice. Mrs. Perlman has given us a very sharp picture of how, in a sense, the social worker steps out of her profession as she moves into private practice, and I agree with her. I feel, however, that basically the psychological training, as well as the casework training, can be a good ground on which to base further training that qualifies one for psychotherapy of nonpsychotic patients.

What does the casework profession propose to do to help the caseworkers who move beyond it? What does the social work profession propose to do to prevent such workers from losing completely their professional identity, to prevent them from feeling as though they were renegades to their profession?

Doctor Woodward: There was a meeting in New York City, recently, an all-day meeting. I could take in only half of it because, being among those who do a certain amount of private social casework, I could not stay all day.

But some 12 decisions or suggestions came out of that meeting on ways in which this sort of thing might be implemented to some extent in terms of setting our own standards. The American Association of Psychiatric Social Workers, having probably been asked to help formulate some standards, officially were asking what extra training one should have had and how supervision and control should be insured. A number of things of that sort were being thought out and spelled out that will take some time, I am sure, to implement adequately. The subject is not just utterly being forgotten. I should think the most important thing is the careful selection of those cases that really require a social casework methodology.

THE FINDINGS OF THE COMMISSION IN COUNSELING AND GUIDANCE

(On the Relation of Psychotherapy to Counseling)

Presented by William G. Perry, Jr.*
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Introduction

The movements that have brought five different professions to contribute to this monograph started almost simultaneously in the first decade of this century. In the year 1908 alone, the First International Congress of Psychoanalysis was held at Salzberg; G. Stanley Hall issued his invitations to Freud and Jung to lecture at Clark University; C. W. Beers launched the mental hygiene movement with *The Mind That Found Itself*; The Rev. Elwood Worcester published *Religion and Medicine: the Moral Control of Nervous Disorders* in connection with the Emmanuel Movement, the first explicit use of psychological theory in pastoral counseling; and Samuel Parsons in Boston and Eli Weaver in Brooklyn set up the quiet beginnings of formal vocational guidance. At the same time, guidance was entering the schools with the work of Wheatley and Boyden in Westport, Conn., and Jesse Davis in Detroit, and the Binet intelligence test was undergoing its first American revisions. Two years later, in 1910, Dewey brought progressive education to the high school level with *How We Think*. Meanwhile, in 1906, the first classes graduated from the New York and the Simmons School of Social Work to enter a field in which Mrs. Adolf Meyer had made, only two years before, the first *rapprochement* of casework and psychiatry. Seen against the backdrop of a vast industrial and educational expansion leavened by the new theories of relativity in both the scientific and cultural sense, these events and the movements they furthered appear as efforts to develop new knowledge and new services to assist individuals who would otherwise be lost or wasted in a new and restless age.

In the years that have followed, these movements have tended to converge, in one respect at least. Guidance, applied psychology, education, social work, mental hygiene, and pastoral counseling have all looked more and more toward dynamic psychology† for the theoretical basis of many of their insights and procedures, while psychiatry, using the same theoretical systems, has emerged from areas of pure pathology into those of prevention and general social adjustment, particularly education. It is at this point that the five professions joined to contribute to this monograph, and the question before them may be phrased "Are we all trying to do the same thing or aren't we?"

Counseling (or guidance) is a process. It is performed in many settings by widely different kinds of people. The other commissions in this conference

* This paper, presented by Doctor Perry at the conference on which this monograph is based, was written by him in collaboration with the other members of the Commission in Counseling and Guidance.

† The phrase "dynamic psychology" will be used throughout this paper to refer both to psychoanalytic theory, which had its origins in the study of pathology, and to the developmental and functional formulations drawn from normal behavior by such psychologists as McDougal, Wilhelm Stern, Harold Jones, Caroline Zaracharry, Piaget, Wermer, Lewin, Murphy, and others.

speak frequently of counseling by the internist, by the social worker, by the psychologist, and by the minister. This commission could have made similar comments for the educator or for specialists in marriage counseling, vocational counseling, industrial personnel work, and so on, and then we could have endeavored to consider the professional problems of these different groups under the general headings outlined as guides for this monograph. We represent, however, people with a common interest but without a common professional organization. The different groups have different problems, and professional standards are as often set by the institutional framework in which the counselor works as by the professional group to which he belongs. Therefore, we shall not examine these problems directly. We shall address ourselves instead to an issue common to counseling in all settings, the nub of so many professional and interprofessional problems, namely: *Is it possible any longer to distinguish theoretically and practically between counseling and psychotherapy?*

It seems to us that even a little clarification of this question would contribute to the solution of many problems of training, practice, and social policy in the many fields and specialties in which counseling and guidance are carried on.

Part 1

Thus far, at least, no one has succeeded in defining psychotherapy in a way satisfactory to anyone else.[1] Nor do we know of an adequate definition of counseling. Most attempts to compare one with the other, furthermore, have been biased by an interest either in making one exclusive of the other, or in making the two entirely indistinguishable. Even less biased comparisons have not been very illuminating, for they have referred to peripheral matters of institutional setting, function, or training, seldom to process.

However, the differences of coloring and emphasis observable in the daily work of those we call psychotherapists and those we call counselors has led a few writers to attempt to differentiate the processes themselves through reference to psychological theory.[2] This paper follows from the work of these writers.

We start with a hypothetical psychotherapist and a hypothetical counselor who are well trained, experienced, and, in an ideal way, representative. We postulate that a systematic examination of their work would reveal the following: while (1) the psychotherapist sometimes does the kinds of things the counselor does most of the time, and while (2) the counselor sometimes does the kinds of things the psychotherapist does most of the time, nevertheless (3) there is, a large part of the time, a sensible difference in the character of what each does. Let us say of this difference that it is somehow a difference *in the direction of regard*, as if the counselor and the psychotherapist were, in their most characteristic moments, attending to matters nearer to different ends of some continuous dimension in the individual's function.

We can begin to outline what we are proposing as in FIGURE 1. Here we distribute the working time of the psychotherapist and counselor along a continuous dimension, and find overlapping distributions of a shape, let us say, like the curves in the figure. The problem we have set ourselves is to de-

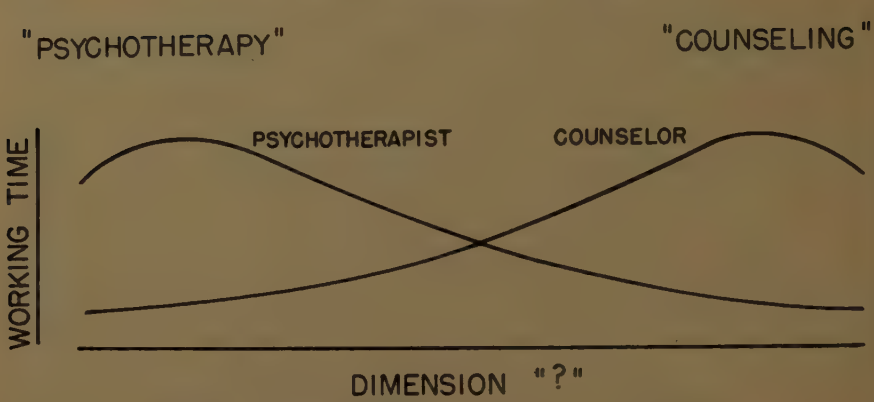

FIGURE 1. Overlapping distribution of process-time on "?" dimension.

fine this dimension. If we can do so, and if we then assume that the activities most characteristic of the counselor are properly called "counseling" and those most characteristic of the psychotherapist are properly called "psychotherapy," we shall be in a position to compare these processes. At present our figure gives us only the form we presume our problem to take, the skeleton on which we plan to build.*

Let us start at some distance and approach the matter afresh. We consider that counseling and psychotherapy exist because of the need of a new function in our society. Our Western culture has added the ideals of "freedom" and of "equal opportunity for all" to a highly complex, multivalued, multiroled society characterized by great economic and moral change. This has produced serious problems for everyone in his transitions from role to role, and in his efforts to cope with multiplicity of roles and with value conflicts. In this way of looking at things, counseling and psychotherapy have developed in our society for the assistance of individuals *in finding themselves in the relation of their personalities and roles.*† In FIGURE 2 we therefore set forth tentatively this dimension linking the individual's personality and the roles in which it is manifest. The arrows indicate the interpenetrating nature of the two poles. To the left, at the "personality" end of the dimension are represented the individual's biology and temperament, the residues of his learned responses in past roles (especially those of early childhood), his present balance in respect to independence-dependence, dominance and submission, and other dynamic variables. At the other pole, we find the roles in which the individual has his social existence, lying in socially describable areas such as education, vocation, marriage.

We should pause here to say that we do not find roles and individuality antagonistic but synergetic. We feel that roles, where they are reasonably loose-

* The paper was constructed for oral delivery. The figures, which are less graphs than "pictures," were intended to convey, when thrown on the screen, the structure of the argument and a rough notion of "how much" difference and "how much" sameness the commission assumes to exist between the activities of representative counselors and psychotherapists.

† For a review of role theory see R. R. Sarbin, 1954, in *A Handbook of Social Psychology*, G. Lindzey, editor, Addison-Wesley, Cambridge, Mass. The terms of the present paper differ from those in Sarbin's formulation in that the term "identity" or "self" is used here to refer to the product of the interaction of "personality" and "roles" where Sarbin uses "personality" to refer to the interaction of the "self" and "roles." Compare with R. Linton, 1947, *The Cultural Background of Personality*, Routledge and Kegan Paul, London, England.

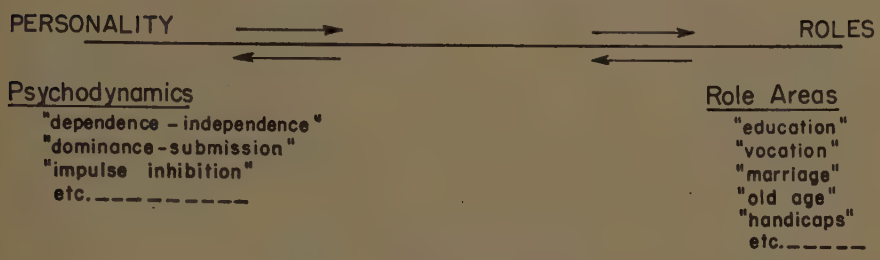

FIGURE 2. The dimension "personality-roles."

fitting, are to be looked upon not as a restriction on the individual, but rather as the cultural patterns or "roughed out" forms through which individuality can alone be finally expressed. Freedom is not, as it is frequently defined in adolescence, freedom "from" the responsibilities and expectations characterizing roles. The ultimate of freedom is the freedom to create an identity through an individual interpretation and use of available roles and through an individual integration of them.

Before going on, we might make our dimension a little clearer by picturing in a perspective drawing in FIGURE 2a a part of the identity of John Doe, thought of as a circle. The center or core of the personality is represented to the left, and we see, radiating from the center, its different manifestations in various roles. Our dimension is a kind of radius that can be rotated through these roles, anchored to the left in the core of the personality from which each role permits, or demands, the expression of different aspects. It is the inter-

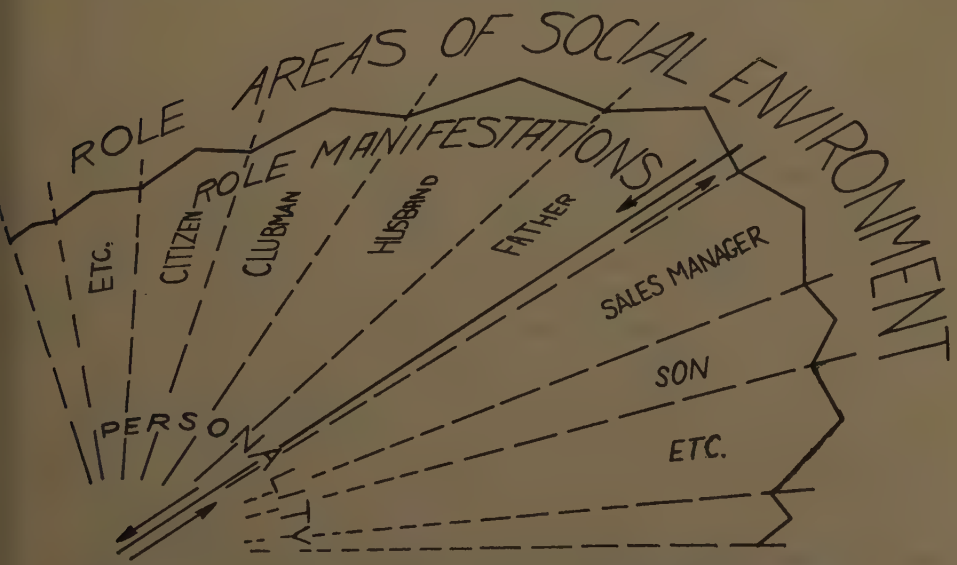

FIGURE 2a. Sector of identity John Doe on dimension "personality-roles." The dimension rotates around a core of personality through the roles in which personality is manifest.

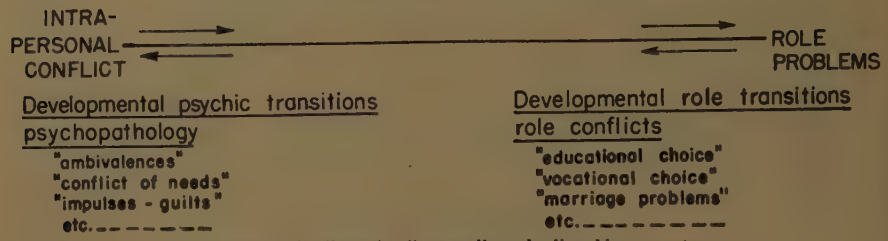

FIGURE 3. The dimension "personality-roles," problem aspects.

action along this dimension, when projected through time, that generates and confirms the individual's sense of selfhood.

It is, of course, when problems arise along this dimension that psychotherapy and counseling become useful. Problems may originate in the developmental processes of the personality, in the abandonment of personality to the demands of role, or in the wanton destruction of roles by the demands of temperament. They may arise in transition from role to role, or in role choice, or in conflicts among multiple roles, or in contradiction of values and role expectations imposed by the complexity and fluidity of the social environment.

Since we conceive of counseling and psychotherapy as processes providing the optimal conditions in which individuals may deal with such problems in the dimension of personality and roles, we now re-express our "dimension" in "problem" terms, as in FIGURE 3. When individual psychodynamics are thought of as problems, we think in terms of intrapersonal conflicts, and we have in mind such problems as the person's intense ambivalences, his inhibiting guilts, or his self-defeating lack of inhibition. We think also of the problems of transition or fixation at different levels of psychic development, conflicts of need, *etc.* But when roles and role choices are thought of as problems, we think in socially describable areas such as vocational choice, marital adjustment, the reorientation required by the limitations of aging, the management of the roles of the physically handicapped, *etc.* At this end are all the specific learning problems posed by social development from role to role and by role conflict. Inevitably, each class of problem will affect processes throughout the dimension.

Conflicts at either end of our dimension may vary in intensity. One can conceive of circumstances posing very serious role conflicts through no "fault" in the individual. So, also, we can think of varying degrees of intrapsychic conflict largely independent of the immediate environmental complexity. For our purposes here, we single out for consideration this latter variable of intensity of internal conflict and, for simplicity's sake, we shall assume a constancy in the degree of environmental stress. We can say that what will most determine how well a person may use his own potential in resolving any problems of role, how rapidly he may integrate or learn, is the degree to which he is free from, or afflicted by, disrupting internal tendencies. In considering what kind of assistance a person can best use, therefore, the *focus* of any personality-role problem may be conceived as located in our dimension in accordance with the intensity of the internal disturbance. In FIGURE 4 we plot, therefore, with the

lower arrows, the variable of intensity of intrapsychic disturbance, starting with the so-called "normal" at the right, where some conflict may be supposed to exist in everyone, and moving to the left to extreme pathological cases merging into the psychoses and extreme behavior disorders. These difficulties, for our purposes, can stem from any of the psychic factors named and also from emotional difficulties resulting from organic disability and requiring special learning. The upper arrows plot, in inverse proportion, the learning capacities of the person, relative to his potential, *vis a vis* whatever role problems he may encounter. That is, we can make the rough statement that the less internally handicapped a person may be by pathological anxiety, depression, or other disturbance, the more he will be able to respond with his full capacities to the

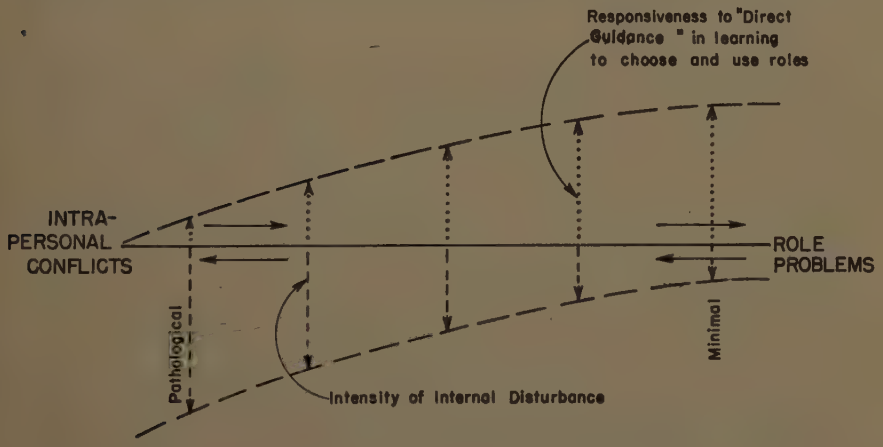

FIGURE 4. Location of a problem along dimension "personality-roles" determined by intensity of intrapersonal disturbance.

briefer and more direct forms of guidance in regard to the skills of choice and management among life's roles. An understanding of his personality may still be of importance in this process, but to put his learning to use, he will not require to re-examine, for instance, primitive beliefs the repression of which has become a pathogenic part of his personality structure. Rather, he rapidly picks up from his guide, be it family, friend, or professional, what he needs to know, with a degree of trust and experimentation which enables him to cope with integrity with many of life's vicissitudes. At the other end of the dimension, however, persons with a strong internal disturbance tend not to be able to make use of direct guidance in its own terms, no matter how kindly or skillful it may be. Instead, they more frequently require a very extended relationship with a single person, or small group of people, whom they test out over a period of time, before they can trust enough, or love enough, to learn effectively the emotional and social skills required for successful handling of the roles expected of them and desired by themselves. In the middle, we have people whose difficulties or disturbances are more reactive and acute than longstanding and im-

bedded. We may find also that the disturbance is less pervasive and more limited to particular roles or role areas. That is, they may be inadequate students or poor husbands but effective in some other area of life. The ameliorative instruction of these people can take a form midway between the two extremes because they have at least the potentiality of transferring successful integrative skills from one role area to another.[3]

We venture now to superimpose from FIGURE 1 our curves which describe the distribution of working time of counselor and psychotherapist. With these before us in FIGURE 5, we can attempt to portray the different colors of counseling and psychotherapy as they facilitate a client's learning to realize his identity—a selfhood expressed as the creative interaction of his "personality," as we have designated it here, with the roles which are available, mandatory, or chosen in his life.

The psychotherapist, as we see it, spends the predominance of his time over a number of cases (or the predominance of his time in a given "typical" case) in areas of moderate to intense intrapersonal disturbance. Even though he may frequently find himself able to help his client or patient directly in learning to handle some role with maturity, his primary concern is with looking with his client more inward toward the process represented at the left end of our dimension and less outward toward the individual's point of immediate contact with the external world. For the psychotherapist, the role problems of his clients are of interest less for themselves and more for the light they throw on inner conflicts. He requires time because his clients do not have, at the level of these conflicts, a prototype for genuine interpersonal trust, and he must start from scratch with his own relationship. Since his major tool must be this dyadic relationship itself, he is characteristically concerned with the dynamics of the client as they are projected on this relation.* It is here, in the contrast of fact with expectation, that his patient will learn both to trust another realistically and to distinguish better between objective and subjective experience.

The counselor must also be concerned with these projections, but the resources of his clients make it possible for him to use many teaching tools, and in his most characteristic work he need not depend primarily on the events of the transference.‡ He spends the predominance of his time over a number of cases (or the predominance of his time in a given "typical" case) in areas of minimal to moderate personal disturbance and in relation to some particular problem area in which he claims a competence, be it vocation, education, marriage, or the like. This is not to say that he never works with persons with intense disturbances. The counselor frequently works in mental hospitals and frequently finds himself, in other institutions, faced with severe behavior problems which have been deemed not suitable for psychotherapy or for whom there are no therapeutic facilities.

* For an insightful use of role theory in the elucidation of the therapeutic process itself see J. P. Spiegel, 1954, *Psychiatry*, 17: 7, 369–376.

‡ No effort is made here to distinguish between transference in the extreme psychoanalytical sense and transference in the general sense of the initial assimilations of all perceptions to a prototype. In his work with normals who have learned in infancy the prototype for a workable trust, the counselor is, of course, making use of a kind of "positive transference."

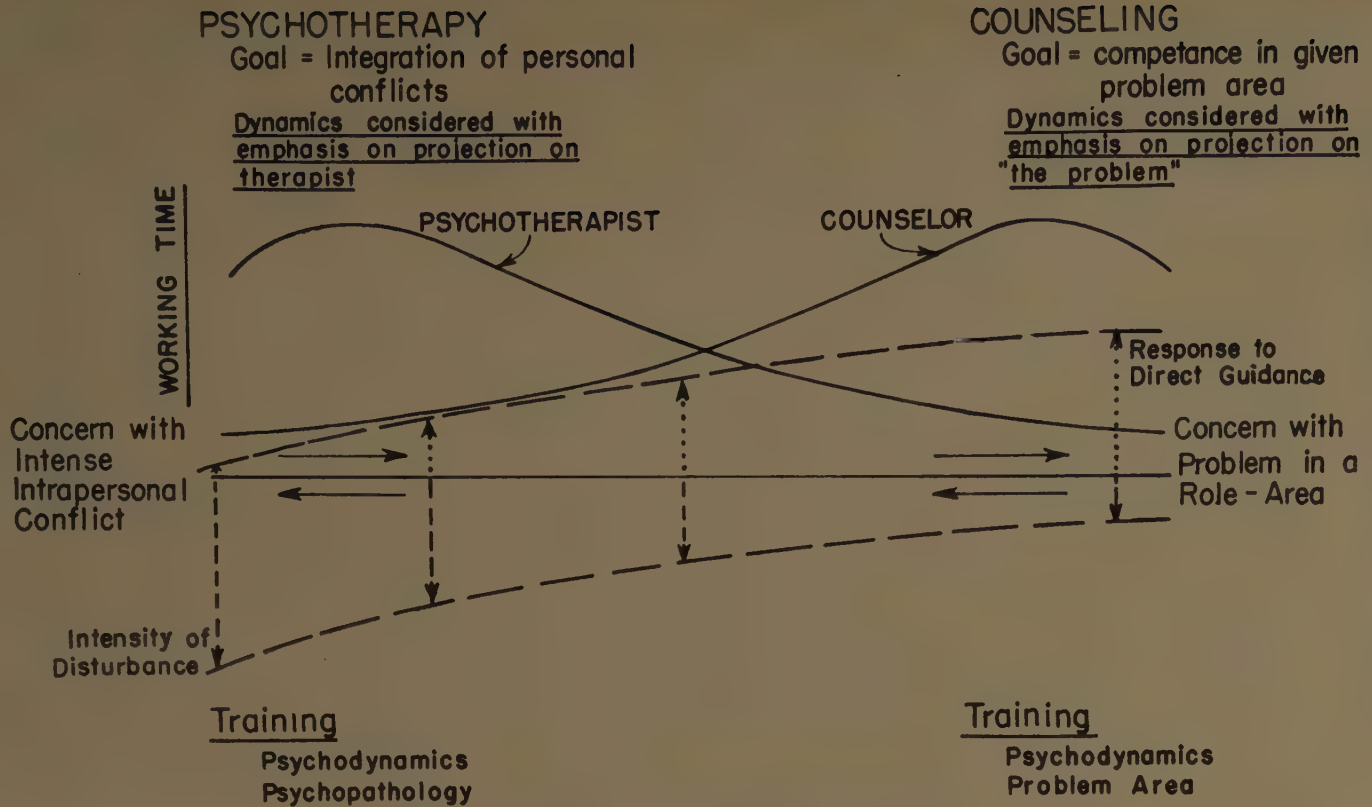

FIGURE 5. Diagrams showing the superposition of FIGURES 1, 3, and 4.

With his more typical clients, a counselor also may make extended excursions into problems of psychodynamics. But when he does so, it is for the most part with the question in mind "What does this tell us that will be useful in attaining a mature competence in the particular roles we are considering (vocation, marriage, *etc.*)?" More consistently than the psychotherapist, the counselor looks with the client outward toward a particular role area. It is this orientation that gives counseling its characteristically triangular rather than dyadic character, a sensed triangle of "client, counselor, role-problem."[4] The felt presence of this "problem," even in the midst of exploration of some sector of deeper dynamics, gives counseling its particular "cast" or character.[5] This characteristic is manifest in action in the tendency of the counselor to be concerned with and to interpret the client's psychodynamics less as they project on the relationship itself and more as they are projected in a given role-area.[6] That is, the client learns about himself through the contrast of expectancy and fact in this role area.*

We can express the difference in emphasis, then, by saying that counseling looks more often toward the interpretation and development of the personality in the relations characteristic of specific role-problems while psychotherapy looks more often toward the reinterpretation and reorganization of malignant conflictual elements within the personality through the relation with the therapist. It is, we believe, from this difference in emphasis that other differences follow that have sometimes been mentioned in distinguishing the two processes—such differences as attention to "ego integration" as against the "analysis of infantile conflict or impulse," attention to "conscious and preconscious material" as against "unconscious" or "repressed," attention to the present as against the past, and so on. (We would rephrase this latter contrast by saying that counseling deals with the future "What shall I do about my problem?" while psychotherapy deals with the present "What am I doing that creates my problems?") The distinction as we have presented it does not, of course, immediately resolve such issues as "when" an internal disturbance shall be categorized as "disease," but the scheme suggests that marginal determinations can be made only in the light of the roles the individual's environment asks him to fill. In any case, the degree of overlap in the work of counselors and psychotherapists in the handling of both mild and more intense disturbances will vary with the institutional setting, training, and temperament of personnel, and perhaps even with their theoretical orientation.

* We feel that so-called "personal counseling" and "psychological counseling" are not the exceptions they would seem to be to this framework. We look on the words "personal" and "psychological" as distinguishing a form of counseling from "marriage" or "vocational" in a correlate sense. This position can be defended on two grounds: (1) In one set of conditions the word "personal" turns out to mean "social"; that is, the person comes to the counselor in concern about his "personality" in the social sense, rather than as we have used it here at the left end of our dimension. Or (2) he comes in a general dissatisfaction in his function in most of his roles; he is looking out at his roles and wondering why he gets no satisfaction out of them. He is in some sense detached from them or unable to commit himself. Where disturbance is not severe, dynamics will be considered in relation to role areas (as at the right hand end of the dimension) and "personal" and "psychological" counseling still have the characteristics which we have described for counseling. It is, of course, true that the word "psychological counseling" is frequently used, or should we say misused, to cover processes which according to our scheme should frankly be called psychotherapy. We feel that in common usage "psychological counseling" is something of a misnomer when applied to the long-term relationship-treatment of a hospitalized hebephrenic schizophrene.

Part 2

Some support for our scheme may be found, we think, in the nature of the interests and bones of contention favored among counselors on the one hand, and among psychotherapists on the other. From what we have been saying, we should be able to predict that the major professional divisions among counselors would be according to problem areas; and so indeed we have vocational counselors, marriage counselors, *etc.* Psychotherapists, on the other hand, would divide professionally according to schools or theories of personality, and so indeed we have Freudians, Adlerians, Jungians, and Washington schools. In their formulations about practice we should expect counselors to differ on matters concerning the triangular relationship of client, counselor, and role-problems. We should expect concern regarding who was to say what about "what the client should do" in respect to his problem. And in fact we do hear debates about the "directive" and "nondirective" procedures. With psychotherapists, on the other hand, we should expect debate regarding the problem of handling the dyadic relationship, and indeed we find that differing views of the "transference" are the major concern.

It seems to follow too that on those regrettable occasions when therapists and counselors point in anger at each other's weaknesses, the psychotherapists should charge the counselor with blindness regarding the exploitation of this transference relationship both by their clients and themselves, while counselors should attribute to the therapists an unworldliness which causes them to impute psychological meaning to sociological variables and transference meanings to objective concerns.

Another interesting validation may be seen in the changes of vocabulary concurrent with the development of the Rogerian school, starting with Roger's book *Counseling and Psychotherapy*[7] in 1942. In this book, the average time reported for cases was 15 hours or less, and concern was mainly with the words "directive" and "nondirective" as illustrated by materials (with the exception of the long case) drawn from counseling in particular problem areas. In 1951, in the book entitled *Client-Centered Therapy*,[8] much longer cases are typical and excerpts from protocols focus on internal conflict. The phrase "client-centered" is of itself a relationship phrase referring specifically to the client-therapist relation, and the book contains an outline of a theory of personality. In 1954, Rogers and Dymond edited *Psychotherapy and Personality Change*.[9] In the index of this book, "Counseling," which had over 200 references indexed in the first book, has one reference followed by "see Therapeutic Relationship," which has 49. In the first book, "Therapy" has five references and "Relationship" three, only one of them long. In the first index, there are numerous references to role areas; in the last, none. We can say, then, that there seems to have been movement in the focus of interest of this school along the dimension we have postulated as central. An extension of interest in the other direction is evident in the writings of psychiatric groups discussing "preventive psychiatry" and the application of psychiatric knowledge to particular areas such as education.[10]

These illustrations suggest only that the two patterns of interests, concepts,

and vocabulary we have postulated for persons attending to either end of our dimension do, in fact, appear in the talk of the professions. However, an empirical study of process itself is entirely possible. Large samples of protocols could be procured and analyzed for frequency of the variables we have mentioned, and norms could be described for therapy and counseling as they occur in various settings. We have hypothesized that one of the most distinctive among these variables will be the degree of concern with psychodynamics projected on the dyadic relationship compared to the degree of concern with psychodynamics projected onto a given problem area.

We ourselves should regret to see such a quantitive study of our scheme used to crystalize practice in a new science. We should be content, however, to have it point to useful clarifications in matters of professional relations and training and in all those issues listed as guides for this monograph. Psychotherapists necessarily must be trained in psychodynamics, in psychopathology, and in the handling of the intense strains placed on their persons in the therapeutic relationship. The counselor in his turn (from whatever other professional field he may come) should be trained in psychodynamics, in the special considerations relevant to his problem area, and in the use of his own person and role in the learning process. Since this role can often resemble that of the regular teacher at his best, teaching experience past or present can be a help to him.

In all professional issues, counselors and psychotherapists who are part of these converging movements can work at greater ease with each other where they can see that each approach has its own integrity, its own special direction of regard. Then this integrity need be neither overreaching nor exclusive, for the psychotherapist and counselor have more in common than an interest in dynamics. Together, their ultimate art lies in their capacity to put their training at the service of their humanity in providing a context where another can grow to know himself and to make the choices that affirm his being.

Ultimately, too, all of us who work in this field can share the feelings that follow on remembering how men have practiced this art (without claim to formal theory and certified training) for thousands of years. When we remember also how small our formal knowledge remains beside the complexity of a human being's concerns and resources, we can accept together the possibility that the recent prestige of our specialties may spring no more from the virtue of our knowledge than from the urgency of the times.

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VOCATIONAL COUNSELING: A SEPARATE DISCIPLINE

(Discussion of the Findings of the Counseling and Guidance Commission)

By Preston David

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Although William G. Perry's paper discusses issues "common to counseling in all settings," my comments will be restricted to the field of vocational counseling. I have no competence in other areas of personal adjustment and, in fact, must question whether the separate counseling disciplines can really be examined as one. The major presentation is a thoughtful paper, but the concept of counseling is much closer to social casework or to psychological counseling than to the separate discipline of vocational guidance.

Perry raises two generalized questions: (1) "Are we (in the various disciplines) all doing the same thing?"; and (2) "It is possible any longer to distinguish theoretically and practically between counseling and psychotherapy?"

As I understand vocational counseling, my answer to the first question would be "No." We are not dong the same thing. And to the second question, my answer would be "Yes." Vocational counseling and psychotherapy can be clearly distinguished, although I cannot say whether the same distinction can so easily be made between therapy and social casework.

I should agree generally with the major lines of Perry's arguments. There can be no quarrel with statements to the effect that therapy focuses in depth on questions of personality disturbance, and that the basic relationship is one between the therapist and the client. Nor that, at the other end of the dimension, counseling focuses upon role problems, the adjustment to which does not necessarily require internal reorganization. I should agree also that even though "in a given case a counselor may. . . .make extended excursions into problems of psychodynamics," the examination of the personality pattern should primarily question "What does this tell us that will be useful to the (vocational) goal we are considering?"

I should like to suggest a modification of the triangular relationship that has been drawn among client, counselor, and role problem. In the vocational field, another element must be added: the dynamic labor market. Vocational counseling, at all times, must understand the decisive nature of work opportunities. With all of the counseling skill in the world, all of the warmth, insight, and understanding, vocational solutions are conditioned or controlled, nevertheless, by impersonal and fluid factors in the economy.

I must question the distinction the paper draws "that the major professional divisions among counselors would be according to problem areas" while psychotherapists "divide professionally according to schools or theories of personality."

Again, I cannot speak for social casework, but the differences between the functional and the diagnostic schools in this field are so basic as to affect curriculum, supervision, placement, and the entire orientation to the practice of the profession. In the field of vocational counseling, the question of how much

emphasis should be placed on the fields of psychological testing, interviewing, job analysis, and other professional tools are theoretical and practical differences influencing the whole matter of counseling theory and technique.

Finally, I should take issue with the statement that attempted definitions of counseling have "not been very illuminating, for they have referred to peripheral matters of institutional setting, function, or training, seldom to process."

I can understand that, in the conference on which this monograph is based, it was in order to examine process in purely theoretical terms. I have been asked to react to the paper as an agency administrator, however, and, from that point of view, it seems to me that institutional setting and function are not "peripheral" matters. Indeed, these are frequently the determining factors in the counseling process. For example, counseling emphasis will differ when the service is given in an autonomous vocational agency and when it is offered through the vocational department of, let us say, a family service agency.

Limited staff, limited budget, and applicant demand are also influential administrative considerations. How much time is allowed for interviews, for recording, for staff training? All of these and more are organizational problems bearing directly upon the counseling process. To say this is not to suggest that these things diminish the quality of service; rather, I submit, structure and function sharpen and discipline professional assistance.

I should like to turn now from the paper to a few remarks about the nature of vocational counseling.

People in trouble seek help among a variety of agencies and professional counseling services. Indeed, when we know that the separate disciplines do not always say with precision what they do or whom they service, we can understand that it is not difficult for clients to walk through the wrong agency door.

Vocational agencies receive applications from people whose problems vary. Vocational adjustment may be the primary need, emotional problems may be dominant, or—in the typical situation—a combination of these factors require a new focus. To the client, half a dozen problems ache as one, and it is the professional service that frequently must sort out those areas in which it can be of help, and those areas where referral to other sources seems indicated.

Perhaps I can underscore the relationship between vocational adjustment and life adjustment generally with a quick look at some of the complicated problems that come to a vocational service. It need not be labored, I assume, that without a constructive plan for work, a potential delinquent may turn into an actual delinquent; that inadequate income can produce a wide range of marital tensions; that a retired worker may lose—along with his income—some measure of status within the family. How many children in child guidance clinics today were "abandoned" by mothers who were forced to find employment? What happens to the retarded adolescent who "bounces" continually from one job to another? And what of the ex-mental patient whose laboriously rebuilt emotional reserves must now face precisely the same job pressures that contributed to the original breakdown?

All of these are vocational problems. Yet the frustrations, the tensions, the

unsatisfied drives attached to work situations have a tremendous impact upon the emotions and the internal defenses of our clients. The conflicts must be understood and related to the vocational plan. But their treatment becomes another matter!

In the process of development, vocational counseling, like other professions, has drawn heavily upon the techniques of the related disciplines. And over the years, the field has been dominated at different times and in different settings by the theories and the currents in psychology, sociology, education, economics, and related areas of knowledge.

Vocational counseling today uses some balance and integration of all of these influences. And it adds specialized knowledge about our complicated industrial civilization: work opportunities and the flow of the labor market, job duties and potential income, the structure and practices of modern industry, economic and sociological trends, labor legislation, union-management relationships, government regulations dealing with the status of the worker, training resources, and related data.

The profession has special skills and an area of function that can be carefully defined. In the past few decades, we have developed rapidly, but, to return to Perry's paper, I wonder at times whether we are not moving too quickly. Although I see no problem in distinguishing between counseling and therapy, the very fact that a commission of the conference on which this monograph is based has been established to review the issue means that many questions of relationship do, in fact, exist.

As I see it, vocational counselors have a major job to do, with tools that have yet to be refined. To go beyond this and to become involved in other areas of personal adjustment, as a major focus of concern, is, I feel, a basic mistake. It is precisely at this point that questions of relationships with other services arise. We have emerged as a discipline, but if our coloration becomes indistinguishable from related fields we shall tend to vitiate the profession.

Vocational counseling can be therapeutic, but is not and should not be therapy. Useful and satisfactory employment often minimizes many neurotic patterns and, conversely, a poor employment situation may magnify emotional strains. But this does not mean that vocational counselors are caseworkers or therapists, any more than the reverse is true.

My view is narrow, or specialized, as you prefer. I do not know that it is popular even in the field of vocational counseling, where there are many signs of movement toward a more generalized form of guidance. For whatever it is worth, however, I have the conviction that it is entirely possible to work through job plans, motivations, and attitudes, without treating basic emotional conflicts. These and other nonvocational problems, I feel, should more properly be dissolved through skillful therapeutic services.

The vocational counselor may help with the immediate or the long-range vocational problem and, in so doing, he must attempt to evaluate all of the complicating sociological and psychological problems. He must, in fact, not only relate these factors to the vocational plan, but he must understand when they are so strong that vocational counseling must be postponed. But to widen the

counseling sphere to matters of internal reorganization is to assume a very questionable responsibility.

It is pertinent to help clients choose colleges, find jobs, and plan trade training. And it is pertinent to help them understand how the constellation of personal, emotional, and family factors must enter into their deliberations. But it is no more pertinent to treat parent-child relationships, marital difficulties, or cultural orientation than it is to assume the duties of a lawyer or a physician, when questions of bankruptcy or tuberculosis similarly modify career choice.

On this point, I am certain that Perry and I should be in full agreement. Let me close on another view we share in common: that the various disciplines will relate to each other with greater comfort when we have developed mutual regard and greater confidence in the integrity of our respective professions.

IS THE DIFFERENCE BETWEEN COUNSELING AND PSYCHOTHERAPY IMPORTANT?

(Discussion of the Findings of the Counseling and Guidance Commission)

By Philip Zlatchin

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You may have gathered that Doctor William G. Perry's paper leaves little room for discussion in his effort to formulate points of difference between counseling and psychotherapy. Doctor Perry's presentation covers a tremendous amount of ground in a very succinct, unified, pointed, and logical way. My hat is off to him for having been able to tie together so much in such a tight package, one having very few gaps and fewer loose ends. At the same time, I recognize from Preston David's comments that further extension, further study, of course, will have to be undertaken. I think the commission has had something of this sort in mind in planning to go beyond the points at which it had to stop its work in order to make this presentation.

As an organizational job, it would seem to me that the commission has done an outstanding piece of work, since the results permit us now to face certain common denominators and to start looking further for the points of difference. I don't think it is going to be easy to find ways of ascertaining these points of difference unless we are willing to struggle along for an extended period in tackling the proposition via research, and through the painstaking testing of suggested hypotheses.

I think our practice has begun to spell out for us some of the kinds of differences that exist between counseling and psychotherapy. I think Doctor Perry's formulation begins to show us how to tackle some of the questions as to what these differences are. We don't have very much in the way of research at this point that tells us about the different approaches that might be employed in examining counseling and psychotherapy. We have a good number of clinical observations. We have a large number of case reports on studying the process and studying outcomes, but none of this material has been pulled together in a way that would permit us to say that we are now able to distinguish clearly the task of the counselor from that of the psychotherapist.

Research methods outlined in the Mowrer volume, in the volume by Rogers and Dymond, and in Aptekar's forthcoming book, when applied to the problem of distinguishing between counseling and psychotherapy, raise such questions as: *How much of what method? What kinds of patients* or *clients* produce *what kinds* and *amounts of change* in *what areas of functioning?* These are only a few of the variables. In addition, what other new methods of helping people are there? But I think you see the complexity of the problem before us. To try to spell out these differences, I suspect, will take considerable time.

One or two comments about Doctor Perry's mention of the dyadic and triangular relationships: it would seem to me that if we look at the psychotherapeutic relationship, with its emphasis upon transference, we see the psychotherapist moving clearly and intensively into this domain, and, as Doctor Perry

mentioned quite pointedly, concentrating on this aspect of the relationship as it relates to the inner "core" or the inner aspects of personality dynamics. The psychotherapist, perhaps, could be sketched in as a relatively more amorphous personage, less crystallized, less real than the counselor, who is farther away but more sharply delineated by his client. The latter tackles the problem much more in terms of the triangularity of client, problem, and counselor, with much less intense direct transference operating between the human beings themselves.

If we could visualize constructs such as these, it might be possible for us to begin to spell out precise ways in which we may proceed to distinguish between counselors and psychotherapists a little more meaningfully. One might ask, why bother trying to distinguish between them? It would seem to me that if we can achieve some of the distinctions in terms of function, in terms of goals and in terms of skill, then we might begin to move toward the kind of proposition that would make it possible for us to say that perhaps there are specific ways in which we can prescribe certain precise kinds of services for known conditions at certain times in an individual's life. At the present time, we find the more usual circumstance in which a client moves toward some kind of helping relationship, toward somebody who happens to be accidentally placed in his path, with the result that he may land in any one of a half dozen different places, with the increased possibility of then bouncing from place to place. It would seem that if we could spell out more sharply focused ways of examining what the nature and severity of the problems are, if perhaps we could begin to see what kinds of skills will produce what kinds of changes, then we should be in a position to be far more selective and economical about the various kinds of skills and services we draw upon for the help, treatment, and counseling of people in our society who are desperately in need. In the last analysis, without getting off into theoretical proposals, I think we have before us now the possiblity of beginning to tackle the early stages of this long term research that lies ahead. Some of the tools for this task are developing. We have a set of constructs here that have been developed by the commission. Others that have been developed will bear extension. Some require modification. At the same time, if we could set our sights programmatically upon the kinds of objectives that have to be spelled out as a mission, we might be able to pin down, eventually, the precise kinds of services that ultimately will help, rather than get in the way of, ourselves and the people we are trying to help.

THE FINDINGS OF THE COMMISSION IN THE MINISTRY

Presented by Wayne E. Oates*
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1. *The Clergyman's Role as Counselor*

Counseling has always been at least implicit in the work of the clergyman in the Jewish and Christian traditions. The clergyman in these faiths has endeavored to give help to people especially at the crisis periods of life: at the time of birth of children, when persons self-consciously commit themselves to the religious community, on the occasion of marriage, when illness or grief or death strike, and at other points along life's way. Such ministry usually has been called "pastoral care" and, through the ages, many clergymen have worked diligently and skillfully at this task.

Despite the long tradition of counseling in the implicit sense among Jewish and Christian clergy, however, it is only comparatively recently that the priest, the minister, and the rabbi have thought of themselves as counselors in the sense in which counseling is understood in this monograph. This formal awareness of counseling as a special part of the pastoral ministry has come about as the result of the following three influences, among others: first, the researches and insights of dynamic psychology and psychiatry have had tremendous impact upon the understanding of the human being as a totality; second, the recent wars have forced the military chaplain to become intensely aware of the manner in which pastoral counseling enters into his ministerial role; third, the gradual introduction of pastoral counseling into the curriculum of theological schools is focusing the attention of most clergy upon this aspect of their future ministry.

It is at this point of formal awareness of himself as a counselor that the clergyman's kinship with all the other helping professions becomes apparent. The pastoral counselor is not exempt from the disciplines required of other effective counselors. His work as a counselor depends upon the mastery of the same sources of knowledge about the functioning of the human personality as does theirs. He takes the scientific insights of others, or he develops his own. And when he does develop his own insights, he arrives at them in the same way as any other careful research worker. If he has effective techniques of counseling, he has acquired them through the same laborious process of critical self-examination as have others. There is no easy road to becoming a good religious counselor, any more than there is an easy road to becoming any kind of effective counselor.

We recognize that there are these and many other points of similarity between the work of the clergyman counselor and other counselors. However, the distinctive feature of his work as counselor deserves our first attention. It is that first, last, and always, he represents the church and religion in the eyes of his counselee. Most of the problems people present to a clergyman have

* This paper, presented by Doctor Oates at the conference on which this monograph is based, was written by him in collaboration with the other members of the Committee in the Ministry.

religious overtones, even if they are not expressed. Whether or not the counselee is aware of the religious element inherent in his problem, the clergyman certainly recognizes it as such. Sometimes even a seemingly mundane problem can become attached to some larger questions of the person's spiritual destiny under God.

It is precisely for reasons of this kind, even though the counselee may not be aware of it, that he chooses to come to the clergyman. As one counselee put it, "You have moral responsibility, and I don't want anyone dealing lightly with my life." Whether this view is a distortion or not is beside the point. The fact remains that this kind of preselection process exists, and it brings to the clergyman-counselor most of the people who come to him for help.

In the eyes of his counselee, the clergyman is the leader of the religious community. On the one hand, this gives him the privilege of taking the initiative toward people in times of need. On the other hand, it tends to prevent a clearly defined situation in which he is formally perceived as a counselor. The reason for this is that the clergyman must also function as preacher, teacher, administrator, and pastoral visitor in turn. In his own eyes, however, the clergyman sees himself always in the larger context of the pastor-parishioner relationship. As far as counseling goes, it means that he functions always as a pastoral counselor, not exclusively as a counselor. His work is distinguished always by the religious setting in which it is done. Both he and his counselee attach religious objectives, resources, and patterns of meaning to the counseling process. This is true whether or not the clergyman, depending upon the counselee and his problem, happens to choose religious terms to understand and to communicate with his counselee. The clergyman's counseling is incidental to, although inseparable from, his relationship to his total group.

In functioning as a counselor, therefore, the clergyman always does so as a representative leader of a religious community. This works out practically in several ways:

First, his responsibility to the total group limits the amount of time he can spend with any one individual, regardless of the amount of training he has as a counselor.

Second, his right to choose or select his counselees is limited.

Third, the clergyman is less free than other counselors to terminate his relationship to his counselees, inasmuch as he is enduringly related to them as communicant members of his congregation.

Fourth, the fact that a clergyman-counselor functions in the larger religious framework may be both a help and a hindrance to therapy. It would be a help to the extent that it would enable the counselee to relate readily in terms of confidence in the counselor. It would be a hindrance if the counselor were to use his position as a clergyman to dominate the counseling situation.

Finally, the clergyman's leadership of a religious community puts him in touch with situations that often would be considered "normal" by the psychopathologists, which nevertheless are severe problems to the person involved.

In summary, then, the clergyman, although a true counselor and, in this sense, one making contact with other counseling professions is, nevertheless,

first and foremost a religious counselor. This latter aspect characterizes his uniqueness as a counselor.

2. *The Clergyman's Counselees*

The clergyman, as has been pointed out, deals at one level or another with anyone who seeks his aid. He cannot select his counselees, as the secular counselor does. Furthermore, the clergyman's primary concern is that his relationship with the counselee be an expression of his unique ministerial role, even though his counselee may be under the care of other professional persons. At the same time, the clergyman is meeting his distinctly religious needs. This concern also underscores the ministerial aspect that can be found even in general, nonclerical counseling.

The minimum fulfillment the clergyman would seek in secular counselors or psychotherapists who treat his parishioners would be that they accept and take into account this religious dimension of their patient's need. Members of other professions may not *be* religious themselves. We hope they are. But what we ask is serious attention to the religious aspects of the needs of their patients or clients. We would go even further than this and refuse to declare religion a specialized function of the clergy in such a way as to relieve the other counselors represented here of the responsibility of dealing realistically with the religion as their counselees and of recognizing it as a matter of real fact in their clients' lives.

The counselees with whom clergymen deal may be divided into two categories: those who *seek* the clergyman for help on a specifically religious problem in their immediate situation; and those to whom the clergyman must go. The first group includes:

(1) Persons having religious conflicts, doubts, and questions. Marital conflicts, for example, often take a specific religious direction. People with such problems often seek help from their priest, rabbi, or minister.

(2) Persons who have committed sins of which they are aware come to clergymen as to representatives of God. They seek God's pardon and forgiveness. This group includes those who go to confession of one kind or another. Included in this group are those whose difficulties are not manifestations of psychopathology.

(3) Convalescent psychiatric patients who feel the need to develop their religious dimension in addition to the psychotherapy they are receiving are turning in increasing numbers to clergymen.

(4) Persons who have misgivings with respect to psychologists, psychiatrists, and psychoanalysts often seek the help of clergymen instead. This group includes those who are afraid to go to psychotherapists because they are uncertain as to the latter's attitude toward religion. This may be a rationalization for avoiding therapy, but it also may have some justification in fact as well.

(5) Patients who are receiving psychotherapy and have questions about the wisdom of continuing therapy bring the question to the clergyman in many instances.

(6) Persons for whom psychotherapy may not be indicated come to the

clergyman. This would include older people who feel isolated and alone, and want to enter into a small group relationship. The church has natural groups already in action for such people.

(7) The fact still remains that persons who cannot afford psychiatric treatment still turn to the church for this form of help. The clergyman is in every town and hamlet, and he is often compelled by circumstances to assume the role of the poor man's psychotherapist.

(8) Finally, the clergyman in many instances gets the kind of person who has been unable to respond to counseling by other counselors. Such an unfortunate person expects a clergyman to perform a "miracle," or to act as his permanent crutch.

We are aware that our counselees often turn to psychiatry, psychology, psychoanalysis, *etc.* Often our counselees feel that we have failed with them, and we merely make note of the fact here that this happens to other counselors also, when their counselees turn to us. This kind of person provides an opportunity and the necessity for a difficult but rewarding kind of collaboration between the clergy and other professional persons.

Now, having seen the kinds of persons who seek out the clergyman, let us look at the second group, *i.e.*, those to whom the clergyman must go. The person who seeks out the minister, priest, or rabbi is best dealt with by measures similar to those that characterize all good counseling and psychotherapy. Other measures must be developed in addition to these, however, to stimulate or uncover an awareness of need among those who do not feel the need for help. The confessional among Catholics and others, the various events of the religious year among Jewish people, and pastoral visitation among all communions serve as points of precounseling contact with such persons.

3. *Collaboration with Other Counselors*

Both in the case of the persons who seek out the clergyman and those whom he must seek, the clergyman of today is becoming more intensely aware of the psychodynamics that motivate the religious behavior of his parish members. He is confronted with the creative tension of deepening his own concept of himself as a minister and, at the same time, incorporating the resources of other professional people in his helpfulness to his people. He genuinely must bring things both new and old out of his treasure.

Increasingly, the clergyman of today is developing both a philosophy and procedure of referral. Referral is a two-way process, and sound relationships between the clergy and other counselors and psychotherapists seem to grow most readily as reciprocal referral becomes more common.

We as clergymen *do* refer persons for many reasons. Some of the reasons are as follows:

(1) Because our time is limited by our other responsibilities to the religious community as a whole, we refer persons who require long-term counseling and psychotherapy.

(2) Because of the limitation of our legal and social responsibility for caring for persons in an uncontrolled environment, we refer persons to legally re-

sponsible therapists who can provide controlled conditions for therapy in hospitals and other institutions. Many of the persons whom we counsel are "acting out" their emotional conflicts, and the ways in which they involve their counselor call for the more detached controls of professional psychotherapeutic settings.

(3) As clergymen, we are often geographically inaccessible to our counselees for a sufficiently sustained time to do anything other than interview them and give referral advice as to counselors who are accessible.

(4) As clergymen, we often refer persons to whom we are related in such a way—socially, ecclesiastically, or in terms of authority—that the structure of our relationship does not permit us the degree of objectivity and detachment necessary for minimal counseling needs.

(5) As counseling clergymen, we refer acute pathologies, particularly in the instances of organic complaints, psychotic and neurotic conditions, and those situations which require institutional resources not under our control or jurisdiction.

These referrals in and of themselves call for an over-all evaluation of the total pastoral situation. But in the processes of counseling and referral, the clergyman does not presume to diagnose and treat illness in the technical medical sense. He does not refer persons, either, in any of these instances simply because the problems are too difficult or time consuming. As a clergyman, he believes that the religious community has a stake in the destiny of the person regardless of how many other persons are attempting to help him. Nor does he, on the same basis, refuse to refer the person lest he seem to be confessing that religion has failed to "cure" him. He calls in specialized help, in this ministry to the total person, in order that he may concentrate more fully on the religious needs of the person.

4. *The Education of the Clergyman as Counselor*

The education of the clergyman as counselor reflects the fundamental fact, noted above, that he is a religious counselor. Consequently, his basic education is as a clergyman, and his training as a counselor fits in an ancillary sense into this general framework. In terms of the specific training of the clergyman as counselor, two levels of such training may be distinguished: (1) preparation in general pastoral counseling for all the clergy; and (2) specialized training for a smaller number.

With reference to general pastoral counseling for all the clergy, the principal objective is to make training in such counseling as widely available as possible. To this end, seminaries and divinity schools are introducing courses at every level in the area of pastoral care, personal counseling, pastoral psychology, and clinical pastoral training. An increasing number of the schools of theology in the American Association of Theological Schools have added professors in these specific subjects since 1945. The major danger at this point is that methods that can best be understood under highly individualized clinical supervision will be taught en masse and that superficially trained instructional staffs will be appointed in order to meet the pressing demand of students. At least four

studies of the problems in which pastors feel the most pressing need for training place pastoral counseling first in the pastors' reports.

The level of specialized training in counseling among clergymen is distinguished by the fact that, in this case, the clergyman has added technical training and professional competence in an allied discipline to his fundamental education as a clergyman. Typically, in such an instance, the clergyman is also a qualified psychologist, social worker, or even psychiatrist. The danger inherent in this kind of specialization is rather obvious. It creates a problem of integration for the individual clergyman, who must find a formula to unite his specialization into his fundamental ministerial work, so that his additional training does not make him less, but more a man of God to those who come to him for counsel and guidance. The danger to the clergy as a whole arises from the possibility of a separation developing within the church by reason of such specialization.

The unanimous thought of this commission is that the creation of a specialty of counseling among ministers, a subprofession, so to speak, is highly undesirable. Teachers, chaplains, and research persons among the clergy will increasingly become more proficient, but the whole reason for this improvement is to intensity the ability of the total clergy rather than to create a "priesthood" within a priesthood, as it were. Education for all the clergy to make them more apt in their primary tasks as representatives of God in the church among men —this is the functional objective. In every instance, the training and efficiency of the clergyman are endowed with the particular meaning of his own identity as a man of God. Everything the clergyman has is subordinate to this fundamental fact.

Some data as to the extent of training in counseling among ministers is relevant at this point.

In the past 30 years, about 4000 Protestant clergy have participated in programs of clinical pastoral training. These programs are conducted in accredited institutional training centers in mental and general hospitals and correctional institutions. Programs are usually 6 or 12 weeks long, although from 30 to 50 clergy annually undertake a year of such training. The 45 to 50 training centers, scattered all over the country, are sponsored by such interdenominational organizations as the Council for Clinical Training, and the Institute of Pastoral Care, or by individual seminaries and denominations. The setting of standards and the accreditation of the Chaplain Supervisors have been matters of concern and action to the National Conference on Clinical Pastoral Training. In the last seven years, there have been established two journals in the field of pastoral care and pastoral psychology.

The Department of Human Relations of the New York Board of Rabbis Institute for Pastoral Psychiatry meets at the Mount Sinai Hospital, New York, N. Y. The department offers a program of lectures on pastoral counseling by outstanding medical and psychiatric authorities. As extensions of this initial project, two additional departments have been founded: the Department of Clinical Pastoral Training and the Department of Pastoral Care, which meet at Bellevue Hospital. The former offers rabbinical students an intensive

three-month summer course; the latter provides training in pastoral guidance and religious ministration for rabbis and chaplains.

As an instance of somewhat more specialized training, reference may be made to the 65 or more priests who are currently members of the American Psychological Association, approximately half of whom have become members within the last six years. Priests in considerable numbers also hold formal degrees in social work, and about a half dozen in the United States are fully qualified psychiatrists.

These data attest sufficiently to the growing conviction on the part of all religious groups of the need for training in pastoral counseling as part of the integral education of the clergyman.

At no point does the fact that the minister works in the context of a larger community appear more vividly than at the point of selection procedures and criteria of selection for prospective candidates for the ministry. This is the function, not of the ministry but of the church as a church, the congregation of the religious community. The church has always desired to secure the best of its members as its leaders in the ranks of the clergy. This fundamental desire has led in recent years to the growing adoption of psychological testing as an adjunct employed in the selection of prospective clergymen. This development seems related to the importance of sound personal adjustment in one who, as a clergyman, would be called upon to counsel others in the problems and crises of life.

5. *Evaluation of the Minister as Counselor*

In considering the evaluation of the work of the clergyman as counselor, it is helpful to distinguish the double criterion according to which the clergyman would evaluate his work, namely, scientific *and* theological. The clergyman is no more exempt from scientific criteria of evaluation of his work as a counselor then he is from the use of scientific techniques in counseling. Here, again, the clergyman acknowledges his kinship with counselors in other disciplines but, at the same time, he is aware that his counseling has an added dimension—the religious aspect—and it is in terms of both of these features that his counseling efforts must be judged.

In terms of scientific criteria of evaluation, the clergyman is aware, as are his colleagues in other disciplines, of the paucity of evaluative data whereby his work as a counselor can be critically judged, its limitations corrected, and its effectiveness enhanced. Besides the general problems of scientific evaluation shared by all counselors, the clergyman discerns additional evaluative problems arising from the religious context in which his counseling is conducted.

In this latter connection, it may be noted that the clergyman counsels predominantly in short-term relationships as a formal counselor, although these relationships are set within the more enduring fellowship of the church. Therefore, some research needs to be done as to the relationship between the "already established" rapport that exists between a clergyman and his counselee and the shortening of the length of time necessary for effective results in counseling. The research in the area of pastoral counseling is just beginning, and more

intensive evaluation of the results of pastoral counseling needs to be done. Clergymen are too quick to accept superficial change as a sign of real improvement. They, like others, have not carefully recorded and followed up their counseling relationships. Clergymen have tended to take at face value fads in psychiatric, psychoanalytic, and psychological theory without developing their own research methods and materials by which to test the assumptions and conclusions of these research persons. Probably the most exhaustive research being done is in the Ph.D. and Th.D. programs of several schools. Only a few crucial beginnings, however, have been made in the recording of pastoral counseling interviews and in the development of quantitative studies of a research nature that test some of the "hunches" pastoral counselors have developed on anecdotal studies of their own hurried experiences with a few people. Also, more studies are needed whereby the psychiatric and psychological theories about religion can be tested.

These criticisms of counseling as done by the clergy imply a criticism of the attempts of many clergymen to counsel "wholesale" from the pulpit. The correspondence of the preaching and counseling situation is profound, however. The difference between the two situations is equally profound, and the commission "views with alarm" the superficial handling of human need in much of American preaching today. Likewise, the same observation would apply to the preaching methodology of many psychologists and psychiatrists who write and lecture today. We would remind both ourselves and our fellow counselors that the processes of spiritual growth and psychological functioning do not permit superficiality.

Furthermore, we would insist, as clergymen, that counseling in the context of the religious ministry must constantly be weighed in the balance of an adequate understanding of the nature and function of religious experience itself. Rightly understood, this is the psychology of religious experience, which includes an examination of religious behavior from a psychological point of view. The clergyman would measure his insight and his techniques in the light of such questions as: "What is psychology's role in interpreting the function of religion in the human organism?" For instance, what light does his analytic "father-figure" concept throw upon religious devotion, and wherein does prophetic religion in history give corrective insights in considering the Freudian theory of projected father figures in religious experience? Another question: "Are there any distinctly theological descriptions of the development of personality that may be studied comparatively with the various concepts of the development of personality set forth by the psychologists?" Another question: "What correlations may be drawn between the end results of idolatry as portrayed in the Biblical account and the end results of pathological interpersonal relationships as portrayed in the neuroses and psychoses?" These are but a few illustrative questions that have "open ends" for reflective thinking on clinical phenomena.

These questions stress a second criterion of evaluation in addition to purely scientific criteria for evaluating the clergyman as a counselor. The clergyman can never lose sight of the uniqueness of his role as a religious counselor, and

hence must evaluate the effectiveness of his counseling also in terms of the spiritual benefit to the counselees. A purely scientific criterion of evaluation that might be sufficient for other counselors will be inadequate for the clergyman. If the latter has succeeded in helping his counselee to a psychological adjustment but nothing more, he may rejoice that, in so doing, he has added to the sum total of human happiness, but he must consider that he has failed as a religious counselor. The clergyman always sees God as a partner in the counseling process, characteristically seeks divine guidance in his counseling work, and feels rather hesitant in attributing to his own efforts whatever success may be achieved in counseling.

These considerations draw the clergy to a deepened realization of the human element in their task, the finitude of their measures, and their need of a vaster view of things as a whole, whereby they see things as they are, and not as their particular biases would cause them to wish to see them. The search for a higher criterion for counseling is not unlike the search of a counselee for the meaning of his life.

When the clergy of all faiths say that man is in the image of God, a part of what they often mean is that something creatively different and unique is in that particular person that distinguishes him from all others and joins him to God at the same time. This reflection helps the clergyman to take the attitude of a student, not only toward his fellow counselors in allied professions, but also toward his counselees.

Who is man and what is the universe? Who are we and where are we going and what is it all about? These are questions that join counselor and counselee alike as spiritual pilgrims in a common quest.

THE PASTOR AS COUNSELOR

(Discussion of the Findings of the Commission in the Ministry)

By Paul E. Johnson
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1. *The Clergyman's Role as Counselor*

The role of the pastor is not his own invention, but a social creation emerging from what is expected of him. In the United States, more than 50 per cent of the population belong to churches and synagogues, and these people look to pastors for counsel. They turn to the pastor, for he represents the concern of the religious community for each person. They expect from him unfaltering personal interest, unselfish devotion to their welfare, and understanding of their inner feelings and needs. He is expected to stand by them in time of illness and death, to help them meet crises, and to bless them in their times of rejoicing as marriage and childbirth.

No pastor can escape the role of counselor unless he turns his back upon these requests and denies his vocation, for he is called to this work. There is a recent trend which puts counseling at the center of his work. More people are coming for counsel and expecting more knowledge and skill than ever before. This requires of the pastor additional resources for which he turns to psychology and psychiatry, to social work and the sciences of man to become more competent in counseling.

2. *The Clergyman's Counselees*

It is not surprising that people come to the pastor with religious problems, but it may be surprising to find them coming with all kinds of problems. Do they expect him to work miracles or know the answers to every question? Not exactly this, but they come to him because they feel related to him through religious fellowship, and they trust that he cares for their souls, wants them to have the best life, and will give them the best that he has to give.

In the Pastoral Counseling Service at Boston University, 1100 interviews were held in 1953. Of these, the leading problems presented were marital problems, parent and child relations, anxiety and guilt, vocation, psychotic trends, self-emergence, sex problems, health problems, education, grief, *etc.*

These persons come because they are related meaningfully to the pastor or other worker who refers them. They are concerned about the meaning and value of life in their particular situation, and hope for deepening understanding that will enable them to cope with life better.

3. *Collaboration With Other Counselors*

It is likely that people bring similar problems to other counselors. How, then, are we distinct? Each profession has a unique competence that is its specialization. The physician deals with medical problems, the social worker with social problems, *etc.* There is likely to be some overlapping, however, as

people want to consider special problems in relation to other areas of life, "to see life steadily and see it whole." The minister deals especially with these larger perspectives of life, the meaning and purpose of it all, the goals for which we strive, the values that are most worth while, and attitudes by which to give our best.

No one is excluded from these larger concerns, and every profession takes bearings from distant goals. We may rightfully expect, then, as the commission has said, that counselors in other professions will acknowledge a religious dimension as meaningful or problematic in the life of most persons, not to be discounted or discarded, but respected and given room for consideration, if not by another profession, at least by recognition that there is something here to work through with a religious counselor.

On careful examination, it would appear that all of the counseling and healing professions have religious motivation underlying their reverence for life, their concern for every person's growth, and their unselfish devotion in faithful service for reasons other than the fee. But they may not intend to be so vocal about these motivations as the religious counselor, or prepared to explore the ultimate meaning of life so extensively as the pastor.

The time for rivalry among our professions has long since passed. No single profession can claim to do the whole job or have all the answers. The inevitable result of specialized services is to become interdependent upon each other for mutual support. Granting this theoretically, we have not yet become a team in the full sense required by the multiple needs of life. We need to know each other better, to listen to each other's talk until we understand the jargon and the conceptual systems by which we operate. We need two-way referrals with consultation and follow-up with reporting and reconsideration in the light of our total experience and perspectives.

4. *Education of the Clergyman as Counselor*

It is true, as the commission finds, that theological education is basic to the education of the pastoral counselor. To qualify for the arduous work of counseling, however, he will need thorough preparation beyond the traditional classroom and library work of theological education. If he is to comprehend the dynamics of personality and interpersonal relations, he will need a systematic sequence of psychological studies and well-guided practice in working face-to-face with people.

Clinical training is essential and now available in many hospitals where the theological student will function in the role of pastoral counselor, supervised by a teaching chaplain with the cooperation of an interprofessional staff. Training may also be available in pastoral counseling centers with individual supervision and participation in regular staff meetings, as provided for doctoral candidates at Boston University.

Every pastor ought to have as much of this training as possible, yet the education should be offered at different levels, as for the parish minister who is equivalent to the general practitioner, and for the special requirements of the

full-time pastoral counselor, the institutional chaplain, or the teacher of other pastors.

The use of psychological tests for selection and guidance of theological students has recently become a general practice. An urgent need not yet widely met is to provide psychotherapy for the pastor as part of his preparation for his vocation. Where there is special need and/or ability to pay, some are having psychiatric therapy. Theological students are also asking for group therapy and pastoral counseling, but the availability of therapists and counselors does not yet equal the demand. When students write up pastoral interviews for group discussion and supervising comments, there is some therapy to be expected in the experience of understanding more deeply what in oneself complicates the counseling relationship. Spiritual exercises of prayer and meditation are also therapeutic.

If our teamwork could advance to the point where theological students might have psychotherapy from psychiatrists, psychologists, or social workers, it would not only improve their mental health, but qualify them better to serve the mental-health needs of the community. Or, again, if seminars could be arranged in more communities where regular case conferences could draw together these counseling and healing professions, there would be continuing education in understanding, skill, and teamwork.

5. *Evaluation of the Minister as Counselor*

Research is needed to evaluate how persons are changed through counseling and what the goals of therapy are to be. Too often we take for granted that if a person feels better he has had successful psychotherapy. But the pleasure principle is not enough. We need to consider also the reality principle of inner character development and outgoing relationships that are to be free of distortion and creative in the production of true values. Religion and philosophy may demonstrate teamwork with the sciences in evaluating these goals of therapy and in discovering what reality principles to take into consideration. Local gains are not sufficient unless human life is true in reference to the larger dimensions of reality that we call God or purpose, human destiny, and ultimate values.

Doctoral research may work in these areas to cope with theoretical issues of significance to the work of psychotherapy and counseling. Doctoral studies have been made in some problems such as: "The Roman Catholic Confessional and Protestant Psychotherapy," "The Place of Grief Work in Mental Health," "Group Therapy as a Method for Church Work," "The Use of Group Psychotherapy in the Professional Training of Ministers," "The Meaning and Development of Empathy in the Mental Hospital," "Client-Centered Therapy and the Christian Doctrine of Man," "The Function of Faith in Psychotherapy," "The Relation of Some Concepts of Salvation and Psychotherapy." These are feeble beginnings, yet they are significant first steps. What is needed now is to enlarge the area and importance of research by developing teamwork among these professions in designing and conducting cooperative research. When

research becomes multidisciplinary, the uncritical assumptions and soft spots of one approach may be corrected by the stimulation of mutual criticism and the encouragement of interpenetration of minds and methods in unified attack upon ıll-defined and elusive problems.

Whether we can talk the same language and work with common symbols is an open question yet to be determined, not by shrugging off the outlander who is not our kind, but by putting our shoulders together and learning to work and laugh and converse together with open minds and generous hearts.

RELIGIOUS AND MORAL ISSUES IN PSYCHOTHERAPY AND COUNSELING

(Discussion of the Findings of the Commission in the Ministry)

By Noël Mailloux
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To anyone who is perusing carefully Reverend Oates' report, it appears evident that the commission has studied the various implications of psychotherapy and counseling in regard to pastoral work in a rather exhaustive manner. Thus, instead of merely attempting to suggest some unmentioned aspects of the problem, one sees the way open for a discussion leading to deeper insights along the proposed lines of investigation. Therefore, within the space allotted to me, I should like to concentrate on issues that seem of major importance for one who is tackling the problem from the specific viewpoint of the clergyman.

In this particular field, indeed, the minister of religion cannot be satisfied with borrowing the knowledge and experience accumulated by members of other professions to develop the skill required for the proper accomplishment of his own work. He must also offer an indispensable contribution in building up the new synthesis that, as this interdisciplinary meeting is suggesting, finally seems to be in the process of being elaborated. Undoubtedly, defining such contributions will increase at once the significance of all the five points considered in the report.

We are certainly justified in requiring that members of other professions pay "serious attention to the religious aspects of the needs of their patients or clients." We must not forget, however, that it is our task to provide them with adequate information about the psychological implications of sound religious practice and of well-balanced virtuous living. It is also vitally important to undertake a thorough empirical study of the developmental, integrative, and dynamic aspects of religious and moral attitudes. But, just as the accumulation of empirical data through systematic observation and even through rigorous experimentation should be one of our primary aims, the correct interpretation of such data in the light of theological knowledge should be a matter of immediate concern to us. Only when such material has become part of our scientific interpretation of human personality will a fully comprehensive basis for psychotherapy and counseling be provided.

We cannot limit ourselves, however, to the study of the normal psychological conditions and manifestations of religious and moral life. Every day, we are confronted in our pastoral work with a whole variety of more or less serious deviations in the functioning of religious and moral conscience. This means, of course, that a whole chapter of psychopathology has yet to be written, perhaps not the least important one. It is our obligation to define the essential requirements for the exercise of human freedom as well as its occasional limitations; to identify and describe man's frequent escapes from responsibility when confronted with values; to investigate the roots of superstitious religiosity and

of a twisted moral judgment. Clinical material will have to be gathered systematically, and, as in any other field of psychopathology, interpretations will have to be attempted that should lead to the formulation of general theories and to the elaboration of appropriate techniques.

Another problem that is a matter of serious concern to us is the reciprocal implications of religion and illness for each other. There are very few emotional disturbances that have no repercussions on an individual's attitudes towards values. The priest often meets tremendous difficulties when he is providing pastoral care to the physically sick individual who is upset by the prospect of death, of doubtful rehabilitation, and even of resuming the full responsibilities of normal life. But coping with these difficulties remains relatively easy as compared to the frightful task of giving proper pastoral care to the depressive or obsessive scrupulous, to the religiously-minded paranoid reformer, to the sexual invert, to the confirmed alcoholic, to the constantly acting-out psychopath, *etc*. Whether the prognosis is good or bad, whether the individual is accepting or refusing psychiatric treatment, the priest must adapt his care to the needs presented to him and provide whatever help can still be offered under these particular circumstances.

On the other hand, it is a fact that inner religious and moral conflicts are liable to produce emotional tension and to create anxiety in certain individuals. Like any other deeply ego-involving experience, the most careful and objective presentation of religious values or of moral imperatives may be unexpectedly upsetting to potential neurotics or psychotics. Occasionally, sinful acts or habits, when they become the focus of conscious attention, begin to stimulate the pangs of latent pathological guilt feelings and precipitate the appearance of a depressive condition accompanied by self-accusatory delusions. The immoral conduct of one member of the family may also have a deeply disturbing effect on the emotional equilibrium of its other members. Almost daily, for instance, a priest has to deal with the appalling consequences for a child of the discovery that his mother is leading a promiscuous life, or of the fact that his father is convicted for a criminal offense.

Finally, it is self-evident that the quality of one's religious and moral attitudes may have a tremendous impact on the course of ordinary therapy. In my opinion, there is great probability that such attitudes very often provide an adequate explanation for the fact that one has or has not the courage of facing reality situations in a way permitting the solution of severe neurotic conflicts and the reduction of dangerously accumulated anxiety. And here, one hesitates to introduce the consideration of other specifically spiritual factors such as prayer, confession, communion, and the other sacraments in general, since their influence will probably always remain beyond the scope of our empirical methods of evaluation.

This rapid presentation, sketchy as it is, will likely be sufficient to increase the awareness that an immense contribution is expected from the minister of religion to this interdisciplinary and uniquely constructive approach towards the understanding and relief of human suffering that may be the greatest achievement of our time.

SUMMARY

By Lawrence K. Frank
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In closing, I wish to remind you that the meeting on which this monograph is based was one step on the way. We do not consider this report to be a definitive pronouncement but a report of progress. It was indicated that there should be some sort of summary. I do not think this is the time to offer any summary, but I should like to emphasize two points that have emerged.

In the first place, I think many of us are convinced that the conference that was held is significant of a pervasive, may I say almost revolutionary, change in the climate of opinion. This change is characterized by a new awareness, a new set of assumptions, a new set of expectations, a particularly different way of thinking about ourselves, physically, biologically, psychologically, and otherwise. We are more or less aware of that. We are more or less responsive to that changing climate of opinion. One dramatic indication of that change is in our altered ways of thinking of human nature. If you reflect on what has been said in these pages, you will get a very clear picture of a rather generally more hopeful and favorable concept of human nature expressed in a variety of ways; an assertion that various kinds of dysfunction, self-defeat, and warping can be reversed under appropriate care and treatment. Individuals suffering from early stunting and distortion can be helped to grow and mature, their strengths and potentialities can be evoked by various processes so that they can develop more nearly in terms of their capabilities.

It is significant that every profession represented in these pages has declared itself a social agent, feeling itself to be a responsible agent dedicated, if you please, to making operational our cherished beliefs in the worth of individual personality. Each group is working in its own way to recognize and conserve the human dignity of man, woman, and child. The mental health program, as I see it, may be said to be an endeavor to translate into practice this conception of human dignity, for instance by bringing up children to achieve a healthy personality.

In the second place, every group here has acknowledged that no single profession is competent to undertake this difficult task of psychotherapy and counseling without further training and clinical experience that goes beyond the M.D., Ph.D., D.D., or whatever the degrees or titles may be. That is very significant, because it gives us a basis from which to go forward as a multidisciplined, multiprofessional group, recognizing that no one person, merely because he has professional training and a degree, can claim that he is competent to undertake this difficult process.

All the professions have given evidence that they are today endeavoring in every possible way to enlarge their awareness in the areas of their professional concern. They are learning, and, what is worth emphasizing, they are trying to unlearn. I should be inclined to say that a professional group is a group that has an obligation to unlearn, to look critically at what it believes and has

accepted from the past in order to discard whatever has become incredible in the light of new knowledge and understanding. I should say there is not enough unlearning in our professional schools, not enough of making the students aware of how much there is of the past that is no longer credible or relevant. This does not mean discarding the past. We pay our debt to the past by trying to do for today what the great figures of the past did in their time. If we gave our professional students that orientation toward their predecessors, we should build up more of this critical awareness and reduce the lags and the archaisms that persist. Students are looking for more credible assumptions upon which they can relate themselves more productively and effectively to other persons. Everyone in these discussions has talked about relating himself to persons, not treating persons, but relating himself to his patients, clients, *etc.* It is that kind of relationship, emphasized in these pages, that is being carried on by every person engaged in any form of psychotherapy and counseling. In these fields we have had, not a clear consensus, but at least a realization that we have to relate ourselves in our various fields of therapy or counseling to an organism-personality. I rather deprecate efforts to say this is biological or psychological or sociological or any other such thing. Persons cannot be fractionated according to our academic disciplines. One way in which we are striving to get a broader awareness and understanding of persons is by recognizing that we cannot be competent in every dimension of the organism-personality but that, at least, we can be aware of all these dimensions and functions.

All of the professions are endeavoring to gain a clearer recognition and conception of a person as always living in a social-cultural field that is as much a part of his personality as it is a part of the so-called outside world. In other words, we are trying to develop a field conception, not limited in Kurt Lewin's model, that enables us to see the person and his life space related in a reciprocal fashion. For a long time we have emphasized the adjustment of individuals to society, and the duties and obligations of the individual to his society. There has been little critical thinking about the reciprocal question of the relation of society to the individual.

That is why some of us are saying that if we want a healthy society or social order, we must develop healthy personalities, and that if we want healthy personalities we must try to develop a healthy social order. That is not a vicious circle, but a recognition of the inextricable and indivisible, circular reciprocal relation of persons and the social order. It is a transaction, to use a recent term indicating that the individual is in the social order and that, concurrently, the social order is in the individuals. When we give people a feeling that they are not merely adjusting to something outside of them, such as gravitation or the weather, but that they are the social order, we shall take a great step forward in giving them a conception of their worth, of their dignity as actual participants in the maintenance of the symbolic cultural world, the cultural world in which each one is significant.

Another thing we are trying to do is to get a clearer understanding of how each profession has more or less specialized in the recognition of various bio-

logical signals, of various psychological signs and symbols in persons that are of major significance to each profession. But each profession more or less ignores or rejects all the other signals, signs, and symbols that are being given by individuals. This multidimensional, multiprofessional approach is an attempt to try to understand what the other fellow's signals are, why he can see and perceive things that we don't.

These discussions, it seems to me, have also indicated that no group has a monopoly of the significant signals, signs and symbols necessary for psychotherapy or counseling, nor has any one group the most credible and productive interpretation of such indicators. That, I believe, is very important because, to the extent to which we see the patient-client living in a social, cultural field or matrix, to that extent we must be multidimensional in our thinking.

We have heard, from almost all of the contributors to this monograph, the need for scientific research, for basing our practices upon scientific evidence and scientific thinking. We can all applaud such statements but, at the same time, we must ask which science because, at the present time, there are many indications that some of us are still relying upon 19th century conceptions of scientific thinking, on 19th century assumptions of scientific validity and credibility. Indeed, some of the major conflicts today are over credibility of evidence, and some professions and disciplines rely upon the kind of particle physics that dealt with anonymous events, where nothing but samples were important and where one looked for statistical regularity, as in the gas laws, and they refuse to accept as evidence anything that does not conform to such a pattern. For the last 40 or 50 years, we have been seeing a new approach in physics that deals, not primarily with anonymous particles, but with identified events. This approach is the clinical method. It is extraordinary how many new methods have been developed in the physical and biological sciences for dealing with identified events that are unknown to many of the people in social and psychological sciences. This is important because we can argue back and forth on a scientific basis, but if a science has already been superseded, if it is not a contemporary science, then our arguments are apt to be of no avail. That issue is at least implicit in some of our discussions. We may be approaching the time (at least I am optimistic about it) when we may see more agreement on scientific concepts, so that we can have an orchestration of professional skills and knowledge. I like the term orchestration because it gets away from "ancillary" and other terms of subordination and superordination. In an orchestra we recognize the unique place, function, and range of every instrument, but we realize that the instruments have to be played with coordination if they are going to be really productive of any theme played in unison. Such a theme, I take it, is: How can we help persons and families to attain their aspirations in a rapidly changing society, especially in a culture that is undergoing a tremendous upheaval? As I said once before, we not only have got to lift ourselves by our bootstraps, but we have got to change our boots while in the air. We must slowly renew our culture, reformulating our enduring old values in terms that are more commensurate with our new understanding, new awareness, and new sensibilities.

One final point I should like to make that seems to me very significant. The concern for the individual personality that has been the core of our Judaic-Christian tradition is now going through a process of desirable secularization in the sense that doctors, nurses, psychologists, and social workers, all the different professions, are gaining an increasing concern for human personality. That is a desirable form of secularization in the sense that concern for the personality is now permeating all of the professions that are beginning to see the person in the patient, as Doctor Lindemann has pointed out. Possibly that will be one of the tremendous contributions of this 20th century we are talking about. I think Father Mailloux was referring to something of that sort.

Printed in the United States of America

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